Approved_____Mayor
Veto _____
Override _____

MEMORANDUM

ED&HS
AGENDA ITEM NO. 4(H)

TO: Honorable Chairperson Barbara Carey-Shuler, Ed. D. and Members, Board of County Commissioners

DATE: March 10, 2004

FROM: George M. Burgess
County Manager

SUBJECT: Request to Advertise RFP No. RW1401 for Acquisition of Professional Health and Support Services for Persons with HIV Spectrum Disease

This Request for Proposals (RFP), attached in substantially completed form and prepared by the Office of Strategic Business Management, is recommended for advertisement.

RFP TITLE:	Health and Support Services for Persons with HIV Spectrum Disease
RFP No.:	RW1401
DESCRIPTION:	Professional health and support services, including: 1) outpatient medical care (primary care and/or specialty care - targeting the general HIV/AIDS population); 2) Minority AIDS Initiative ("MAI") outpatient medical care (primary care and/or specialty care - targeting minority populations); 3) prescription drugs; 4) case management (targeting the general HIV/AIDS population); 5) MAI case management programs (targeting minority populations); 6) substance abuse counseling - residential; 7) outreach services (targeting the general HIV/AIDS population); 8) MAI outreach services (targeting minority populations); and, 9) health insurance services.
MINIMUM QUALIFICATIONS:	Proposers must satisfy the minimum qualifications requirements specified in Section 2.0, of the RFP, "Scope of Services."

FUNDING SOURCE:	Title I - HIV Emergency Relief Grant under the Ryan White Comprehensive AIDS Resources Emergency (C.A.R.E.) Act of 1990, as amended in 1996 and 2000 (U.S. Health Resources and Services Administration). It is anticipated that Miami-Dade County's award, for the 12-month period beginning March 1, 2004, will total approximately $27.024 million in grant funds. Continuation award recommendations will be presented to the Board of County Commissioners on March 16, 2004 to support existing service programs totaling approximately $23.134 million. In addition, five (5) percent of the total grant award ($1.351 million) will be reserved by the County to support costs associated with the administration of the grant. The remaining grant funds of approximately $2.539 million will be awarded through this RFP for health and support services for persons with HIV spectrum disease. The dollar figures allocated to the service categories included in this RFP are contingent upon the County receiving the anticipated level of funding and may be adjusted at the discretion of the Miami-Dade HIV/AIDS Partnership, a County board established by the Board of County Commissioners, as required under the Ryan White Title I C.A.R.E. Act, to determine funding allocations and service priorities. Similarly, federal legislation gives the Partnership the authority to modify the services included in this RFP and determine the service categories to be funded.
COST ESTIMATE:	Approximately $2.539 million.
TERM:	Approximately 6 months (9/20/04 through 2/28/05)
USING/MANAGING DEPARTMENT:	Office of Strategic Business Management
REVIEW COMMITTEE:	Not Applicable
EST. ADVERTISEMENT DATE:	April 22, 2004

Corinne Brody

REQUEST FOR PROPOSALS FOR
HEALTH AND SUPPORT SERVICES FOR
PERSONS WITH HIV SPECTRUM DISEASE

RYAN WHITE - TITLE I
RFP NO. RW1401

ATTENDANCE AT A PRE-PROPOSAL CONFERENCE IS STRONGLY RECOMMENDED. THE PRE-PROPOSAL CONFERENCE WILL BE HELD ON WEDNESDAY, APRIL 28, 2004, AT 10:00 A.M. (E.S.T.)
AT
STEPHEN P. CLARK CENTER
111 NW 1st STREET, 18th FLOOR CONFERENCE ROOM 18-4
MIAMI, FLORIDA 33128-1983
(SPACE IS LIMITED TO ONE REPRESENTATIVE PER ORGANIZATION)

ISSUING DEPARTMENT:
Miami-Dade County, Office of Strategic Business Management
Ryan White Title I Program
140 West Flagler Street, Room 1604
Miami, Florida 33130

RFP Contracting Officer: Yocasta Juliao, Project Director
Telephone: (305) 375-4742 Fax: (305) 375-4454

PROPOSALS ARE DUE AT THE ADDRESS SHOWN BELOW NO LATER THAN

Friday, May 14, 2004, at 2:00 P.M. (E.S.T.)
AT
CLERK OF THE BOARD OF COUNTY COMMISSIONERS
STEPHEN P. CLARK CENTER
111 N.W. 1st STREET, 17TH FLOOR, SUITE 202
MIAMI, FLORIDA 33128 -1983

PROPOSALS WILL BE OPENED PROMPTLY AT THE TIME AND PLACE SPECIFIED. PROPOSALS RECEIVED AFTER THE FIRST PROPOSAL HAS BEEN OPENED WILL NOT BE OPENED AND WILL NOT BE CONSIDERED. THE RESPONSIBILITY FOR SUBMITTING A PROPOSAL TO THE CLERK OF THE BOARD OF COUNTY COMMISSIONERS ON OR BEFORE THE STATED TIME AND DATE WILL BE SOLELY AND STRICTLY THE RESPONSIBILITY OF THE PROPOSER. MIAMI-DADE COUNTY IS NOT RESPONSIBLE FOR DELAYS CAUSED BY ANY MAIL, PACKAGE OR COURIER SERVICE, INCLUDING THE U.S. MAIL, OR CAUSED BY ANY OTHER OCCURRENCE.

MIAMI-DADE COUNTY IS AN EQUAL OPPORTUNITY EMPLOYER AND DOES NOT DISCRIMINATE BASED ON AGE, GENDER, RACE, OR DISABILITY.

Visit the County Department of Procurement Management Website:
http://www.miamidade.gov/dpm

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DEFINITIONS

The following words and expressions used in this Solicitation (i.e., RFP) shall be construed as follows, except when it is clear from the context that another meaning is intended:

1) The words "Contractor" or "Provider" to mean the Proposer that received any award of a Contract from the County as a result of this RFP, which is also to be known as "the Prime Contractor," "the Prime Consultant," or "the Service Provider."

2) The word "County" to mean Miami-Dade County, a political subdivision of the State of Florida.

3) The word "Department" to mean the Office of Strategic Business Management.

4) The words "Proposer," "Submitter," or "Respondent" to mean the person, firm, entity or organization submitting a response to this RFP.

5) The words "Scope of Services" or "Scope of Work" to mean Section 2.0 of this RFP, which details the work to be performed by the Contractor or Provider.

6) The word "Solicitation" to mean this Request for Proposal (RFP) document and all associated addenda and attachments.

7) The words "Subcontractor" or "Subconsultant" to mean any person, firm, entity or organization, other than the employees of the Contractor or Provider, who contracts with the Contractor or Provider to furnish labor, or labor and materials, in connection with the work or services to the County, whether directly or indirectly, on behalf of the Contractor or Provider.

8) The words "Work," "Services," "Program," "Project," or "Engagement" to mean all matters and things that will be required to be done by the Contractor in accordance with the Scope of Services and the terms and conditions of this RFP (i.e., Solicitation).

9) The words "Work Order" to mean a document that defines and describes the parameters of individual projects assigned or awarded by the County to the Contractor in accordance to the terms of the Contract.

SECTION 1.0 - RFP OVERVIEW AND PROPOSAL PROCEDURES

1.1 INTRODUCTION/BACKGROUND

Miami-Dade County, hereinafter referred to as the "County," as represented by the Miami-Dade Office of Strategic Business Management, is requesting/soliciting proposals from one or more qualified public or private non-profit and for-profit health and support service providers, hereinafter referred to as the "Proposer," to provide the following services to persons with HIV spectrum disease: 1) outpatient medical care (primary care and/or specialty care - targeting the general HIV/AIDS population); 2) Minority AIDS Initiative ("MAI") outpatient medical care (primary care and/or specialty care - targeting minority populations); 3) prescription drugs; 4) case management (targeting the general HIV/AIDS population); 5) MAI case management programs (targeting minority populations); 6) substance abuse counseling - residential; 7) outreach services (targeting the general HIV/AIDS population); 8) MAI outreach services (targeting minority populations); and, 9) health insurance services.

It should be noted that during past funding years, the County was able to award contracts to private for-profit entities that submitted qualified proposed service programs eligible for Title I funding. However, based on the 1996 reauthorization of the Ryan White Comprehensive AIDS Resource Emergency (CARE) Act, Title I funds may not be awarded to private for-profit entities, unless such entities are the "only available provider of quality HIV care in the area." [SEC 2604(b)(2)(A); SEC 2613(a)(1)]. Please refer to **Attachment 1** for additional information regarding this legislation. Private not-for profit service providers must be able to show proof of such status by submitting appropriate documentation in the name of the proposing organization and any subcontractors, if applicable, as part of the proposal (i.e., a Letter of Determination issued by the Internal Revenue Service stating not-for-profit status).

It is anticipated that the County will enter into more than one contract as a result of this RFP process. The initial term of the contract to be awarded shall be approximately five (5) to six (6) months commencing no later than ten (10) days after approval by the Board of County Commissioners which is anticipated to be September, 9, 2004 and continuing through February 28, 2005, with possible options to renew. The maximum, total dollar amount available in this RFP is approximately $2.539 million. The maximum funding allocation for each service is indicated as part of the service definition.

Miami-Dade County receives federal funds from the Title I - HIV Emergency Relief Grant under the Ryan White Comprehensive AIDS Resources Emergency (C.A.R.E.) Act of 1990, as amended in 1996 and 2000. This legislation represents the largest dollar investment made by the federal government specifically for the provision of services for poor or underserved members of the population with HIV infection. The purpose of the Act is to improve the quality and availability of care for individuals and families with HIV disease and establish services for HIV and AIDS patients who would otherwise have no access to health care.

Title I of this Act directs grant assistance to metropolitan areas with the largest numbers of reported cases of AIDS to meet emergency service needs. The Board of County Commissioners authorized the County Manager to apply for, receive, and subsequently

disburse these funds. In accordance with the terms of Title I of the Ryan White C.A.R.E. Act, the Board of County Commissioners also created and established the Miami-Dade HIV/AIDS Partnership (Partnership), whose purpose is to determine the needs and service priorities in our community in order to properly allocate these funds; develop a comprehensive plan for the delivery of HIV health services; and assess the efficiency of the administrative mechanisms to rapidly allocate funds to the areas of greatest need.

It is anticipated that Miami-Dade County will receive approximately $27.024 million in total funding for FY 200-4 –05 (March 1, 2004 – February 28, 2005) from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA). Community members, members of the Miami-Dade HIV/AIDS Partnership, and persons living with HIV spectrum disease participated in interviews, surveys, focus groups, and a quantified needs assessment, which led to the development of the information utilized by the Partnership.

The service priorities, service descriptions, price caps, medical and economic client eligibility requirements, and the standards of service discussed in this RFP were developed by the Miami-Dade HIV/AIDS Partnership.

Miami-Dade County is issuing this RFP for services funded under Title I of the C.A.R.E. Act. It is the County's intention to solicit proposals from as many respondents as are interested, to evaluate the proposals, to conduct oral presentations if necessary, to verify the information presented and to negotiate and award agreements to the top ranked Proposers selected for funding. Proposers may respond to any one service, all services, or any combination thereof.

Proposers MUST have relevant experience in the service(s) for which they are applying for funds.

1.2 RFP TIMETABLE

The anticipated schedule for this RFP and contract approval is as follows:

1. RFP available for distribution (1:00 P.M. E.S.T.)..... 04/23/04

2. Pre-Proposal Conference (10:00 A.M. E.S.T.)..... 04/28/04
   (See Section 1.5 for location)

3. Deadline for receipt of written questions (5:00 P.M. E.S.T.)..... 04/30/04

4. Deadline for receipt of proposals (2:00 P.M. E.S.T.)..... 05/14/04
   (See Section 1.4 for location)

5. Evaluation/Selection process.....05/19/04 – 06/02/04

6. Oral presentations, if conducted.....TBA

7. Projected award date..... 09/09/04

8. Projected contract start date..... 09/20/04 or earlier

1.3 RFP AVAILABILITY

Copies of this RFP may be obtained by contacting or visiting:

Yocasta Juliao, Project Director
Ryan White Title I Program
Office of Strategic Business Management
140 West Flagler Street, Room 1604
Miami, Florida 33130
(305) 375-4742

To request the RFP document through the United States Postal Service, mail your request with the following information: the RFP number and title, the name of Proposer's contact person, Proposer's name, complete address to be mailed to, telephone number and fax number.

Proposers or Respondents who obtain copies of this RFP from sources other than the County's Office of Management and Budget risk the potential of not receiving addenda, since their names will not be included on the list of organizations participating in the process for this particular RFP. Such Proposers or Respondents are solely responsible for those risks (see Section 1.8).

1.4 PROPOSAL SUBMISSION

All proposals MUST be submitted on 8 ½" X 11" paper, neatly typed on one side only, with normal margins and spacing. An unbound, one-sided original and fifteen (15) unbound copies (a total of 16) of the complete proposal must be received by Friday, May 14, 2004, at 2:00 P.M. (E.S.T.). The proposal will be opened by the issuing department in conjunction with the Clerk of the Board at 2:00 p.m. the same day. The original and all copies must be submitted in a sealed envelope or container stating on the outside the Proposer's name, address, telephone number, the RFP number (No. RW1401), the RFP title ("Health and Support Services for Persons with HIV Spectrum Disease"), and the proposal due date of Friday, May 14, 2004 to:

Miami-Dade County
Clerk of the Board of County Commissioners
Stephen P. Clark Center
111 N.W. 1st Street, 17th Floor, Suite 202
Miami, Florida 33128 -1983

Hand-carried proposals may be delivered to the above address **ONLY** between the hours of 8:00 A.M. and 4:30 P.M., Mondays through Fridays (however, please note that proposals are due at the Clerk of the Board of County Commissioners' Office no later than the date and time indicated in Section 1.2. Additionally, the Clerk of the Board is closed on holidays observed by the County.). Proposers are responsible for informing any commercial delivery service, if used, of all delivery requirements and for ensuring that the required address information appears on the outer wrapper or envelope(s) used by such service.

The Proposal Title Page **(Attachment 2)** and the Price Forms **(Attachments 20-21a and 22-24b)** **MUST** be signed by an authorized officer of the Proposer who is legally authorized to enter into a contractual relationship in the name of the Proposer, and the Proposer **MUST** affix the organization's corporate seal to these documents. In the absence of a corporate seal, the Proposal Title Page and Price Forms **MUST** be notarized by a Notary Public. The original copy of the proposal **MUST** be clearly marked as such on the envelope and on the Proposal Title Page. Additional signed copies do not need to bear original signatures, corporate seal, and/or be notarized.

The submittal of a proposal by a Proposer will be considered by the County as constituting an offer by the Proposer to perform the required service(s) at the stated fee(s)/price(s).

1.5 PRE-PROPOSAL CONFERENCE/EXAMINATION OF SITE

A Pre-Proposal Conference has been scheduled for Wednesday, April 28, 2004 10:00 A.M. (EST). The conference will be held at the following location:

Stephen P. Clark Center
111 NW 1st Street, 18th Floor Conference Room 18-4
Miami, Florida 33128-1983

Attendance at the Pre-Proposal Conference is **strongly recommended**, but not mandatory. **Space will be limited to one representative per organization**. Proposers interested in attending the conference are expected to inform the RFP Contracting Officer no later than 24 hours before the scheduled date. Proposers are encouraged to submit any questions in writing to the RFP Contracting Officer, Yocasta Juliao, Project Director, Ryan White Title I Program, at the Office of Strategic Business Management , Fax # (305) 375-4454 **(see Section 1.6).** Questions must be submitted by the deadline indicated in the RFP Timetable **(see Section 1.2).**

A site visit will not be required.

1.6 CONE OF SILENCE

Pursuant to Section 2-11.1(t) of the Miami-Dade County Code, as amended, a "Cone of Silence" is imposed upon each RFP or RFQ after advertisement and terminates at the time the County Manager issues a written recommendation to the Board of County Commissioners. The Cone of Silence **prohibits any communication** regarding RFPs or

RFQs between, among others:

- potential proposers, service providers, lobbyists or consultants **and** the County's professional staff, including, but not limited to, the County Manager and the County Manager's staff, the Mayor, County Commissioners or their respective staffs;
- the Mayor, County Commissioners or their respective staffs **and** the County's professional staff including, but not limited to, the County Manager and the County Manager's staff; or
- potential proposers, service providers, lobbyists or consultants, any member of the County's professional staff, the Mayor, County Commissioners or their respective staffs **and** any member of the respective selection committee.

The provisions do not apply to, among other communications:

- oral communications with the staff of the Vendor Information Center, the responsible Procurement Agent or Contracting Officer, provided the communication is limited strictly to matters of process or procedure already contained in the RFP document;
- oral communications at pre-proposal conferences, oral presentations before selection committees, contract negotiations during any duly noticed public meeting, public presentations made to the Board of County Commissioners during any duly noticed public meeting; or
- communications in writing at any time with any County employees, official or member of the Board of County Commissioners unless specifically prohibited by the applicable RFP or RFQ documents.

Proposers must file a copy of any written communications with the Clerk of the Board, which shall be made available to any person upon request. The County shall respond in writing and file a copy with the Clerk of the Board, which shall be made available to any person upon request. Written communications may be in the form of e-mail, with a copy to the Clerk of the Board at CLERKBCC@MIAMIDADE.GOV.

In addition to any other penalties provided by law, violation of the Cone of Silence by any proposer shall render any RFP award or RFQ award voidable. Any person having personal knowledge of a violation of these provisions shall report such violation to the State Attorney and/or may file a complaint with the Ethics Commission. Proposers should reference Section 2-11.1(t) of the Miami-Dade County Code for further clarification.

This language is only a summary of the key provisions of the Cone of Silence. Please review Miami-Dade County Administrative Order 3-27 for a complete and thorough description of the Cone of Silence.

All proposers will be notified in writing when the County Manager makes an award recommendation to the Board of County Commissioners.

The Contracting Officer for this RFP is Ms. Yocasta Juliao, Project Director, Ryan White Title I Program, Miami-Dade County Office of Strategic Business Management, 140 West Flagler Street, Room 1604, Miami, Florida 33130, telephone number (305) 375-4742, fax number (305) 375-4454.

1.7 CONTRACT MEASURES

No Black/Hispanic/Women Business Enterprise measures have been assigned to this RFP.

1.8 ADDITIONAL INFORMATION / ADDENDA

Requests for additional information or clarifications **MUST** be made in writing and received by the County's Contracting Officer for this RFP, in accordance with Section 1.6 above, no later than the deadline for receipt of questions specified in the RFP Timetable **(see Section 1.2).** The request **MUST** contain the RFP number and title, Proposer's name, name of Proposer's contact person, address, phone number, and facsimile number.

Electronic facsimile requesting additional information will be received by the RFP Contracting Officer at the fax number specified in Section 1.6 above. Facsimiles **MUST** have a cover sheet which includes, at a minimum, the Proposer's name, name of Proposer's contact person, address, number of pages transmitted, phone number, facsimile number, and RFP number and title.

The County will issue responses to inquiries and any other corrections or amendments it deems necessary in written addenda issued prior to the proposal due date. Proposers should not rely on any representations, statements or explanations other than those made in this RFP or in any written addendum to this RFP. Where there appears to be conflict between the RFP and any addenda issued, the last addendum issued shall prevail.

It is the Proposer's responsibility to assure receipt of all addenda. The Proposer should verify with the designated RFP Contracting Officer prior to submitting a proposal that all addenda have been received. Proposers are required to acknowledge the number of addenda received as part of their proposals **(Attachment 3).**

Proposers who obtain copies of this RFP from sources other than the County's Office of Management and Budget risk the potential of not receiving addenda, since their names will not be included on the vendor distribution list for this particular RFP. Such Proposers are solely responsible for those risks.

1.9 PROPOSAL GUARANTEE DEPOSIT

No Proposal Guarantee Deposit is required for this RFP.

1.10 MODIFIED PROPOSALS

A Proposer may submit a modified proposal to replace all or any portion of a previously submitted proposal up until the proposal due date and time. The Evaluation/Selection Committee will only consider the latest version of the proposal.

1.11 WITHDRAWAL OF PROPOSALS

Proposals shall be irrevocable until contract award unless the proposal is withdrawn. A proposal may be withdrawn in writing only, addressed to the County Contracting Officer for this RFP **(in accordance with Section 1.6),** prior to the proposal due date and time or upon the expiration of ***ONE HUNDRED EIGHTY (180)*** calendar days after the opening of proposals.

1.12 LATE PROPOSALS, LATE MODIFICATIONS AND LATE WITHDRAWALS

Proposals received after the proposal due date and time are late and will **NOT** be considered. Modifications received after the proposal due date and time are also late and will not be considered. Letters of withdrawal received either after the proposal due date and time or after contract award, whichever is applicable, are late and will **NOT** be considered.

Proposals will be opened promptly at the time and place specified. Proposals received after the first proposal has been opened will **NOT** be opened and will **NOT** be considered. The responsibility for submitting a proposal to the Clerk of the Board on or before the stated time and date is solely and strictly the responsibility of the Proposer. Miami-Dade County is **NOT** responsible for delays caused by any mail, package or courier service, including the U.S. mail, or caused by any other occurrence.

1.13 RFP POSTPONEMENT/CANCELLATION

The County may, at its sole and absolute discretion, reject any and all, or parts of any and all proposals; re-advertise this RFP; postpone or cancel, at any time, this RFP process; or waive any irregularities in this RFP or in the proposals received as a result of this RFP.

1.14 COSTS INCURRED BY PROPOSERS

All expenses involved with the preparation and submission of proposals to the County, or any work performed in connection therewith, shall be borne by the Proposer(s). No payment will be made for any responses received, nor for any other effort required of or made by the Proposer(s) prior to commencement of work as defined by a contract approved by the Board of County Commissioners.

1.15 BUSINESS ENTITY REGISTRATION

Miami-Dade County requires business entities to complete a registration application with the Department of Procurement Management before doing business with the County. Proposers need not register with the County to present a proposal; however, the selected Proposer(s) must register prior to award of a contract, as failure to register may result in the rejection of the Proposal. To register, or for assistance in registering, contact the Vendor Information Center (305) 375-5773.

It is the responsibility of the business entity to update and renew its application concerning any changes, such as new address, telephone number, commodities, etc. during the performance of any agreement obtained as a result of this RFP.

Section 2-11.1(d) of Miami-Dade County Code as amended by Ordinance 00-1, requires any county employee or any member of the employee's immediate family who has a controlling financial interest, direct or indirect, with Miami-Dade County or any person or agency acting for Miami-Dade County from competing or applying for any such contract as it pertains to this RFP, must first request a conflict of interest opinion from the County's Ethics Commission prior to their or their immediate family member's entering into any contract or transacting any business through a firm, corporation, partnership or business entity in which the employee or any member of the employee's immediate family has a controlling financial interest, direct or indirect, with Miami-Dade County or any person or agency acting for Miami-Dade County and that any such contract, agreement or business engagement entered in violation of this subsection, as amended, shall render this Agreement voidable. For additional information, please contact the Ethics Commission hotline at (305) 579-2593.

1.16 ORAL PRESENTATIONS

The County may require Proposers to give oral presentations, if necessary, in support of their proposals or to exhibit or otherwise demonstrate the information contained therein. If required, the presentations will be announced as indicated in this RFP Timetable **(see Section 1.2)**.

1.17 PROPOSER REGISTRATION AFFIDAVIT

Proposers are advised that in accordance with Section 2-11.1 (s) of the Code of Miami-Dade County, the attached Affidavit of Miami-Dade County Lobbyist Registration for Oral Presentation **(Attachment 4) MUST** be completed, notarized and included with the proposal submission. Lobbyists specifically include the principal, as well as any agent, officer or employee of a principal, regardless of whether such lobbying activities fall within the normal scope of employment of such agent, officer or employee.

Individuals substituted for or added to the presentation team after submittal of the proposal and filing by staff, **MUST** register with the Clerk of the Board and pay all applicable fees.

NOTE: Other than for the oral presentation, Proposers who wish to address the Board of County Commissioners, County Board or Committee concerning any actions, decisions or recommendations of County personnel regarding this RFP in accordance with Section 2-11.1(s) of The Code of Miami-Dade County, Florida and Ordinance 01-162 must register with the Clerk of the Board **(Form BCCFORM2DOC)** and pay all applicable fees.

1.18 EXCEPTIONS TO THE RFP

Proposers may take exceptions to any of the terms of this RFP unless the RFP specifically states where exceptions may not be taken. All exceptions taken must be specific, and the Proposer must indicate clearly what alternative is being offered to allow the County a meaningful opportunity to evaluate and rank proposals, and the cost implications of the exception (if any).

Where exceptions are taken, the County shall determine the acceptability of the proposed exceptions. The County, after completing evaluations, may accept or reject the exceptions. Where exceptions are rejected, the County may insist that the Proposer furnish the services or goods described herein, or negotiate an acceptable alternative.

All exceptions shall be referenced by utilizing the corresponding Section, paragraph and page number in this RFP. However, the County is under no obligation to accept any exceptions. If no exception is stated, the County will assume that the Proposer will accept all terms and conditions.

1.19 PROPRIETARY / CONFIDENTIAL INFORMATION

Proposers are hereby notified that all information submitted as part of, or in support of, proposals will be available for public inspection after opening of proposals, in compliance with Chapter 119, Florida Statutes, popularly known as the "Public Record Law."

The Proposer shall not submit any information in response to this RFP, which the Proposer considers to be a trade secret, proprietary or confidential. The submission of any information to the County in connection with this RFP shall be deemed conclusively to be a waiver of any trade secret or other protection, which would otherwise be available to Proposer. In the event that the Proposer submits information to the County in violation of this restriction, either inadvertently or intentionally, and clearly identifies that information in the proposal as protected or confidential, the County shall endeavor to redact and return that information to the Proposer as quickly as possible, and if appropriate, evaluate the balance of the proposal. The redaction or return of information pursuant to this clause may render a proposal nonresponsive.

1.20 NEGOTIATIONS

The County may award a contract on the basis of initial offers received, without discussions. Therefore, each initial offer should contain the Proposer's best terms from a monetary standpoint.

The County reserves the right to enter into contract negotiations with the selected Proposer(s). If the County and the selected Proposer(s) cannot negotiate successful contracts, the County may terminate said negotiations and begin negotiations with another selected Proposer(s). This process will continue until contracts acceptable to the County have been executed or all Proposals are rejected. No Proposers shall have any rights against the County arising from such negotiations or termination thereof.

1.21 RIGHTS OF PROTEST

Any Proposer may protest any recommendations for contract award or rejection of all proposals in accordance with the procedures contained in **Attachment 5** of this RFP. Due to specific Federal requirements on the grievance process implemented by grantees of Title I funds, Proposer(s) are advised that this process must be utilized to file a protest or grievance. Any remedies that result from the grievance process will be prospective in nature. Please refer to **Attachment 5** for additional information on the Miami-Dade County Ryan White Title I Grantee Grievance Procedures and Process.

1.22 LOCAL PREFERENCE

The evaluation and ranking of proposals is subject to Ordinance 01-21 and Resolution No. R-514-02, which, except where Federal and State law mandates to the contrary, provides that a preference be given to a local Proposer if in the final ranking it is within 5% of the highest ranked Proposer and the highest ranked Proposer is a non-local business. Local business means the proposer, has a valid occupational license issued by Miami-Dade County or Broward County, at least one year prior to the proposal due date, to do business in Miami-Dade County that authorizes the business to provide the goods, services or construction to be purchased, and a physical business address located within the limits of Miami-Dade or Broward County from which the vendor operates or performs business. Post Office Boxes are not verifiable and shall not be used for the purpose of establishing said physical address. If the County extends local preferences to other counties, those counties will participate in local preference considerations.

The Proposer should complete, sign and submit **Attachment 6**, "Local Business Preference," with the technical proposal in order to be considered for Local Preference.

1.23 RULES, REGULATIONS, AND LICENSING REQUIREMENTS

The Proposer shall comply with all laws, ordinances and regulations applicable to the services contemplated herein, especially those applicable to conflict of interest and collusion. Proposers are presumed to be familiar with all Federal, State and local laws, ordinances, codes, rules and regulations that may in any way affect the goods or services offered, especially Executive Order No. 11246 entitled "Equal Employment Opportunity" and as amended by Executive Order No. 11375, as supplemented by the Department of Labor Regulations (41 CFR, Part 60), the Americans with Disabilities Act of 1990 and implementing regulations, the Rehabilitation Act of 1973, as amended, Chapter 553 of

Florida Statutes and any and all other local, state and federal directives, ordinances, rules, orders and laws relating to people with disabilities.

1.24 REVIEW OF PROPOSALS FOR RESPONSIVENESS

Each proposal will be reviewed to determine if the proposal is responsive to the submission requirements outlined in the RFP. A responsive proposal is one which follows the requirements of the RFP, includes all documentation, is submitted in the format outlined in the RFP, is of timely submission, and has the appropriate signatures as required on each document. Failure to comply with these requirements may result in a proposal being deemed non-responsive.

1.25 CRIMINAL CONVICTION

Pursuant to Miami-Dade County Ordinance No. 94-34, "Any individual who has been convicted of a felony during the past ten years and any corporation, partnership, joint venture or other legal entity having an officer, director, or executive who has been convicted of a felony during the past ten years shall disclose this information prior to entering into a contract with or receiving funding from the County." Accordingly, Criminal Record Affidavit forms are available upon request at the Department of Procurement Management/Vendor Information Center at (305) 375-5773 for those individuals or firms requesting to disclose this information only.

1.26 QUARTERLY REPORTING WHEN SUB-CONTRACTORS ARE UTILIZED

Proposer(s) are advised that when subcontractors or subconsultants are utilized to fulfill the terms and conditions of this contract, Miami-Dade County Resolution No. 1634-93 will apply to this contract. This resolution requires the selected Proposer to file quarterly reports as to the amount of contract monies received from the County and the amounts thereof that have been paid by the contractor directly to Black, Hispanic and Women Owned businesses performing part of the contract work.

Additionally, the listed businesses are required to sign the reports, verifying their participation in the contract work and their receipt of such monies. For purposes of applicability, the requirements of this resolution shall be in addition to any other reporting requirements required by law, ordinance or administrative order.

1.27 INSPECTOR GENERAL REVIEWS

A. Independent Private Sector Inspector General Review

Pursuant to Miami-Dade County Administrative Order 3-20 and in connection with any award issued as a result of this RFP, the County has the right to retain the services of an Independent Private Sector Inspector General ("IPSIG"), whenever the County deems it appropriate to do so. Upon written notice from the County, the selected Proposer shall make available, to the IPSIG retained by the County, all requested records and documentation

pertaining to this RFP or any subsequent award, for inspection and copying. The County will be responsible for the payment of these IPSIG services, and under no circumstance shall the Proposer's cost/price for this RFP be inclusive of any charges relating to these IPSIG services. The terms of this provision herein, apply to the Proposer, its officers, agents, employees and assignees. Nothing contained in this provision shall impair any independent right of the County to conduct, audit or investigate the operations, activities and performance of the selected Proposer in connection with this RFP or any contract issued as a result of this RFP. The terms of this provision are neither intended nor shall they be construed to impose any liability on the County by the selected Proposer or third party.

B. Miami-Dade County Inspector General Review

According to Section 2-1076 of the Code of Miami-Dade County, as amended by Ordinance No. 99-63, Miami-Dade County has established the Office of the Inspector General which may, on a random basis, perform audits on all County contracts, throughout the duration of said contracts, except as otherwise provided below. The cost of the audit on any contract issued as a result of this RFP shall be one quarter (1/4) of one (1) percent of the total contract amount which cost shall be included in the total proposed amount. The audit cost will be deducted by the County from progress payments to the selected Proposer. The audit cost shall also be included in all change orders and all contract renewals and extensions.

Exception: The above application of one quarter (1/4) of one percent fee assessment shall not apply to the following contracts: (a) IPSIG contracts; (b) contracts for legal services; (c) contracts for financial advisory services; (d) auditing contracts; (e) facility rentals and lease agreements; (f) concessions and other rental agreements; (g) insurance contracts; (h) revenue-generating contracts; (i) contracts where an IPSIG is assigned at the time the contract is approved by the Commission; (j) professional service agreements under $1,000; (k) management agreements; (l) small purchase orders as defined in Miami-Dade County Administrative Order 3-2; **(m) federal, state and local government-funded grants;** and (n) interlocal agreements. **Notwithstanding the foregoing, the Miami-Dade County Board of County Commissioners may authorize the inclusion of the fee assessment of one quarter (1/4) of one percent in any exempted contract at the time of award.**

Nothing contained above shall in any way limit the powers of the Inspector General to perform audits on all County contracts, including, but not limited, to those contracts specifically exempted above.

1.28 PUBLIC ENTITY CRIMES

Pursuant to Paragraph 2(a) of Section 287.133, Florida Statutes, a person or affiliate who has been placed on the convicted vendor list following a conviction for a public entity crime may not submit a proposal for a contract to provide any goods or services to a public entity; may not submit a proposal on a contract with a public entity for the construction or repair of a public building or public work; may not submit proposals on leases of real property to a public entity; may not be awarded or perform work as a contractor, supplier, subcontractor, or consultant under a contract with any public entity; and, may not transact business with any

public entity in excess of the threshold amount provided in Section 287.017 for CATEGORY TWO ($10,000) for a period of thirty-six (36) months from the date of being placed on the convicted vendor list.

1.29 REQUIRED LISTING OF SUBCONTRACTORS AND SUPPLIERS ON COUNTY CONTRACTS

Miami-Dade County Ordinance 97-104, amended by Ordinance 00-30, requires a bid or proposal for a County or Public Health Trust contract involving the expenditure of $100,000 or more to include a listing of subcontractors and suppliers who will be used on the contract. The required listing must by filed prior to the contract award. The required listing must be submitted even though the Proposer will not utilize subcontractors or suppliers on the contract. In the latter case, the listing must expressly state no subcontractors, or suppliers, as the case may be, will be used on the contract.

ATTACHMENT , OR A COMPARABLE LISTING MEETING THE REQUIREMENTS OF ORDINANCE NO. 97-104, AS AMENDED BY ORDINANCE NO. 00-30, MUST BE COMPLETED AND SUBMITTED EVEN THOUGH THE PROPOSER(S) MAY NOT UTILIZE SUBCONTRACTORS OR SUPPLIERS FOR THIS PROPOSAL. THE PROPOSER(S) SHOULD ENTER THE WORD "NONE" UNDER THE APPROPRIATE HEADING(S) ON ATTACHMENT 7 IN THOSE INSTANCES WHERE NO SUBCONTRACTORS AND/OR SUPPLIERS WILL BE USED ON THIS PROPOSAL.

1.30 FAIR SUBCONTRACTING POLICIES (Ordinance 97-35)

All selected Proposers on County contracts in which subcontractors may be used shall be subject to and comply with Ordinance 97-35 as amended, requiring Proposers to provide a detailed statement of their policies and procedures for awarding subcontracts which:

a) notifies the broadest number of local subcontractors of the opportunity to be awarded a subcontract;
b) invites local subcontractors to submit bids/proposals in a practical, expedient way;
c) provides local subcontractors access to information necessary to prepare and formulate a subcontracting bid/proposal;
d) allows local subcontractors to meet with appropriate personnel of the proposer to discuss the Proposer's requirements; and
e) awards subcontracts based on full and complete consideration of all submitted proposals and in accordance with the Proposer's stated objectives.

All Proposers seeking to contract with the County shall, as a condition of award, provide a statement of their subcontracting policies and procedures **(see Attachment 8).** Proposers who fail to provide a statement of their policies and procedures may not be recommended by the County Manager for award by the Board of County Commissioners.

The term "local" means having headquarters located in Miami-Dade County or having a place of business located in Miami-Dade County from which the contract or subcontract will be performed.

The term "subcontractor" means a business independent of a Proposer that may agree with the Proposer to perform a portion of a contract.

The term "subcontract" means an agreement between a Proposer and a subcontractor to perform a portion of a contract between the Proposer and the County.

1.31 AFFIRMATIVE ACTION / NON-DISCRIMINATION OF EMPLOYMENT, PROMOTION AND PROCUREMENT PRACTICES (Ordinance No. 98-30)

In accordance with the requirements of County Ordinance No. 98-30, all firms with annual gross revenues in excess of $5 million seeking to contract with Miami-Dade County shall, as a condition of award, have a written Affirmative Action Plan and Procurement Policy on file with the County's Department of Business Development. Said firms must also submit, as a part of their proposals/bids to be filed with the Clerk of the Board, an appropriately completed and signed Affirmative Action Plan/Procurement Policy Affidavit **(see Attachment 9).** Firms whose Board of Directors are representative of the population make-up of the nation are exempt from this requirement and must submit, in writing, a detailed listing of their Boards of Directors, showing the race or ethnicity of each board member, to the County's Department of Business Development. Firms claiming exemption must submit, as part of their proposals/bids to be filed with the Clerk of the Board, an appropriately completed and signed Exemption Affidavit **(see Attachment 10)** in accordance with Ordinance No. 98-30. These submittals shall be subject to periodic reviews to assure that the entities do not discriminate in their employment and procurement practices against minorities and women-owned businesses.

It will be the responsibility of each firm to provide verification of their gross annual revenues to determine the requirement for compliance with the Ordinance. **Those firms that do not exceed $5 million annual gross revenues must clearly state so in their bid/proposal.**

1.32 AFFIDAVIT - PAID FEES, TAXES, PARKING TICKETS AND OBLIGATIONS ARE NOT IN ARREARS

In accordance with Section 2-8.1 (c) of the Miami-Dade County Code, and as amended by County Ordinance No. 00-30, and Section 2-8.1(h) as amended by Ordinance No. 00-67, the Proposer shall certify that all delinquent and currently due fees, taxes and parking tickets have been paid and that the Proposer is not in arrears on obligations to the County **(see Attachment 11).**

1.33 CODE OF BUSINESS ETHICS

In accordance with section 2-8.(1) of the Code of Miami-Dade County each person or entity that seeks to do business with Miami-Dade County shall have or shall adopt a Code of

Business Ethics ("Code") and shall, prior to execution of any contract between the contractor and the County, submit an affidavit stating that the contractor has adopted a Code that complies with the requirements of Section 2-8.1(i) of the Miami-Dade County Code **(Attachment 12)**. Any person or entity that fails to submit the required affidavit shall be ineligible for contract award.

1.34 BANKRUPTCY

Any Proposer who, at the time of proposal submission, is involved in an ongoing bankruptcy as a debtor, or in a reorganization, liquidation, or dissolution proceeding, or if a trustee or receiver has been appointed over all or a substantial portion of the property of the Proposer under federal bankruptcy law or any state insolvency law, may be non-responsive.

1.35 DOMESTIC VIOLENCE LEAVE AFFIDAVIT

Prior to entering into any contract with the County, a firm desiring to do business with the County shall, as a condition of award, certify that it is in compliance with the Domestic Leave Ordinance, 99-5 and Section 11A-60 of the Miami-Dade County Code **(Attachment 13).** This Ordinance applies to employers that have, in the regular course of business, fifty (50) or more employees working in Miami-Dade County for each working day during each of twenty (20) or more calendar work weeks in the current or preceding calendar year. In accordance with Resolution R-185-00, the obligation to provide domestic violence leave to employees shall be a contractual obligation. The County shall not enter into a contract with any firm that has not certified its compliance with the Domestic Leave Ordinance. Failure to comply with the requirements of Resolution R-185-00, as well as the Domestic Leave Ordinance may result in the contract being declared void, the contract being terminated and/or the firm being debarred.

1.36 ORDINANCES, RESOLUTIONS AND/OR ADMINISTRATIVE ORDERS

To request a copy of any ordinance, resolution and/or administrative order cited in this Solicitation, the Proposer must contact the **Clerk of the Board at (305) 375-5126.**

1.37 DISABILITY NONDISCRIMINATION AFFIDAVIT

Proposers must complete the attached Disability Nondiscrimination Affidavit **(Attachment 14)** certifying that their organization, and any subcontractor or third party under this project, is in compliance with and agrees to continue to comply with all requirements of the Americans with Disabilities Act (ADA). This shall include but will not be limited to posting a notice informing service recipients and employees that they may file any complaints of ADA violations directly with Miami-Dade County Office of Strategic Business Management, Ryan White Title I Program, 140 West Flagler Street, Room 1604, Miami, Florida 33130.

1.38 DISQUALIFICATION OF PROPOSALS

Due to Federal requirements, the Proposer(s) MUST submit a categorical (line-item) budget **(Attachment 15)** and narrative justification using the object class categories listed below. **(Attachment 16)** provides a set of guidelines for the preparation of a budget justification as well as examples of allowable direct and indirect costs for each Title I service category. All expenses associated with the provision of the proposed service(s), including indirect costs, must be presented on the budget form using the object class categories identified below. Failure to submit the categorical budget with your proposal will **DISQUALIFY** your submittal from further consideration by the Evaluation/Selection Committee for award of funds.

Object Class Categories

1. Personnel
   - Salaries, Fringe benefits
2. Contractual
3. Supplies
4. Travel
5. Equipment
6. Other Direct Costs
7. Total Indirect/Administrative Charges (Proposers are required to identify individual administrative costs under object class categories 1 through 6 above, and indicate the total sum of these costs).

1.39 MIAMI-DADE COUNTY VENDOR INFORMATION CENTER

The Departments of Procurement Management and Business Development are pleased to announce the availability of the Miami-Dade County Vendor Information Center (VIC), located at 111 N.W. 1st Street, Suite 112 (Ground Floor), Miami, Florida, 33128 **(Attachment 17)**. The VIC provides information and assistance in doing business with Miami-Dade County, vendor registration and certification, and current contracting opportunities Countywide.

In addition, the VIC offers bid and proposal preparation workshops on the 2nd and 3rd Tuesdays of each month, respectively. These workshops are free of charge. For more information, please call the VIC at (305) 375-5773.

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SECTION 2.0 SCOPE OF SERVICES

2.1 GENERAL PHILOSOPHY OF SERVICE PROVISION (INTRODUCTION / BACKGROUND)

In order to insure comprehensive, continuous, and integrated care, the successful Proposer(s) will be required to commit to a coordinated case management system that promotes high standards of service and care, staff training, and the development of service linkages and referral mechanisms among participating care providers. Proposer(s) should maintain an overall philosophy that HIV infection is a chronic illness in which, with proper management, the client's quality of life can in many cases be improved and maintained over an extended period of time. ***The goal is to achieve 100% access to quality care and 0% disparity in health outcomes among HIV/AIDS infected individuals, especially among communities of color.***

2.2 PRIORITIES & SERVICE PROVISION REQUIREMENTS

The services included in this RFP will be provided with priority to underserved medically indigent individuals with HIV spectrum disease who meet Federal Poverty Guidelines **(Attachment 18),** and who, after proper screening for eligibility under other benefits program, do not qualify fully/or partially to receive these services outside of Ryan White Title I. Services may also be provided to non-indigent clients, but such clients' economic conditions must meet Federal Poverty Guidelines and be charged fees based on a sliding-fee schedule that meets Federal guidelines. Recipients of Ryan White Title I services must be permanent residents of Miami-Dade County. **No cash may be provided to clients.**

2.3 SPECIAL POPULATIONS & GEOGRAPHIC ACCESSIBILITY

Proposer(s) must demonstrate a capability to serve clients from a geographic area beyond that of a local neighborhood, and to do so in keeping with the cultural/ethnic sensitivities of the population(s) to be served. Furthermore, special attention must be given to underserved populations, for example, low-income uninsured and medically indigent individuals and families, including women, children, youth, communities of color particularly the African-American, Haitian and Hispanic communities, pediatric and homeless populations, migrant farm workers, youth, men who have sex with men, hemophiliacs, sex workers and substance abusers.

Special consideration will be given to Proposers that demonstrate the ability to offer service sites located within the major centers of the epidemic in Miami-Dade County or areas that historically have been underserved. According to the Miami-Dade HIV/AIDS Partnership most current Needs Assessment , based on Miami-Dade County Health Department data, the areas (or Life Zones) with the highest numbers of people diagnosed with HIV are: Life Zone IV: Liberty City, North Miami, Little Haiti, El Portal, and Miami Shores; Life Zone V: Brownsville, Model City, Allapattah, and Wynwood; and Life Zone III: Miami Beach. Areas of the County with a large proportion of infections to the general population are Life Zone 1:

Hialeah, Miami Lakes, and Miami Springs; Life Zone II: Carol City, Opa Locka, North Miami Beach; and, Life Zone VI: Little Havana, Overtown, and the Roads.

2.4 CLIENT FINANCIAL ELIGIBILITY

Service providers should consider, as part of the client's financial screening, any and all "out of pocket" medical expenses incurred by the client in relation to his/her care. These expenses must be documented and the appropriate deduction must be made from the client's income in order to accurately determine his/her eligibility for Title I services.

2.5 SCOPE OF SERVICES REQUESTED

To assist Proposers in developing service programs, the anticipated maximum dollar amount available for each service category appears at the end of each service description and a summary of reimbursement rates and client eligibility criteria is provided as **Attachment 19**.
NOTE: No exceptions may be taken to the requirements set forth in this section.

The County is currently seeking public or private (not-for-profit and for-profit) service providers under this Request for Proposals. As a reminder, during past funding years, the County was able to award contracts to private for-profit entities that submitted qualified proposed service programs eligible for Title I funding. However, based on the 1996 reauthorization of the Ryan White Comprehensive AIDS Resource Emergency (CARE) Act, Title I funds may not be awarded to private for-profit entities, unless such entities are the "only available provider of quality HIV care in the area." [SEC 2604(b)(2)(A); SEC 2613(a)(1)]. Please refer to Attachment 1 for additional information regarding this legislation. Private not-for profit service providers must be able to show proof of such status by submitting appropriate documentation in the name of the proposing organization and any subcontractors, if applicable, as part of the proposal (i.e., a Letter of Determination issued by the Internal Revenue Service stating not-for-profit status).

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THE FOLLOWING SERVICES ARE AVAILABLE UNDER THIS REQUEST FOR PROPOSALS:

I. Outpatient Medical Care

This service category includes **Primary Care** and **Outpatient Specialty Care** required for the treatment of individuals infected with the HIV virus.

Primary Care

General management of acute and chronic medical conditions or prevention of such conditions through initial visit and intake, complete history and physical examination, lab tests necessary for evaluation and treatment, nutritional counseling, immunizations, follow-up visits and maintenance, appointments as indicated on the basis of clinical status, and referrals to other medical specialists as necessary. Respiratory therapy needed as a result of HIV infection may be provided as part of primary care services. Treatments offered by specialty care providers are described under Outpatient Specialty Care services.

Special consideration will be given to providers who employ persons living with HIV/AIDS (PLWHs or PLWAs) and include them in the provision of service.

a. **Program Operation Requirements:** To focus on timely/early medical intervention and continuous health care and disease care over time, as patient conditions progress. Primary care services may be provided by outpatient hospital clinics, neighborhood health centers, migrant or homeless clinics, private not-for-profit health centers, HMOs, pediatricians, OB/GYN or private physicians.

   Providers of primary care services will be expected to offer and post walk-in hours to ensure maximum accessibility to outpatient medical care.

   Providers of primary care services will be expected to offer basic education to clients on various treatment options, including information about state of the art combination drug therapies. Primary care providers will be expected to educate clients on the importance of complying with their medication regimen with the objective of reducing the risk of developing and spreading a resistant virus, and to ensure a healthy life for the client. Primary care providers are expected to encourage clients to take medications as prescribed and follow the recommendations made by physicians, nutritionists, and therapists regarding medication management. Frequent contact must be maintained with other caregivers (i.e., the client's case manager, nutritionist, home health care nurse, outpatient specialty care physician, pharmacist, counselor, etc.) and with the client in order to monitor that he/she adheres to his/her medication schedule. In addition, primary care providers must ensure that the client receives coordinated, interdisciplinary support for adherence and assistance in overcoming barriers to meeting treatment objectives.

Primary care providers will also be expected to empower clients to be actively involved in the development and monitoring of their treatment and adherence plans, and must ensure that immediate follow-up is available for clients who miss their prescription refills and/or who experience difficulties with adherence. Primary care providers must assist clients with becoming knowledgeable about HIV/AIDS, with gaining greater understanding of CD4 counts, viral load, adherence and resistance concepts. It is also expected that primary care providers will help clients understand the reason for treatment; will help identify and address the possible factors affecting adherence; will help the client to successfully run trials with colored candies or other similar methods, if needed; and, will help the client understand his/her treatment schedule.

Special emphasis is placed on low-income uninsured persons, especially women, including non-pregnant women; migrant farm workers; adolescents; and homeless individuals.

Providers should demonstrate a history and capacity to serve Medicaid eligible clients.

Providers of outpatient primary care services are required to identify a single point of contact for case management and outside agencies who have a client's signed consent and require information.

b. Service Delivery Standards: Providers of this service will adhere to the *Public Health Service Clinical Guidelines for the Treatment of AIDS Specific Illnesses, Title I System-wide Standards of Care* and the *Minimum Primary Medical Care Standards for Chart Review.*

Guidelines: Providers must adhere to the following clinical guidelines for treatment of AIDS specific illnesses:

- Guidelines for the Use of Antiretroviral Agents in HIV-Infected Adults and Adolescents. U.S. Public Health Service, November 10, 2003.

- Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection. U.S. Public Health Service, January 20, 2004.

- U.S. Public Health Service Task Force Recommendations for the Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV-1 Transmission in the United States, November 26, 2003.

- A Guide to the Clinical Care of Women with HIV/ AIDS, Jean Anderson, MD, U.S. Department of Health and Human Services, Health Resources and Services Administration, 2001 First Edition.

- 2001 USPHS/ISDA Guidelines for the Prevention of Opportunistic Infections in Persons Infected with Human Immunodeficiency Virus. U.S. Public Health Service/IDSA, November 28, 2001.

- In addition, providers are encouraged to adhere to other generally accepted clinical practice guidelines.

Standards:

- Primary care providers or identified key direct primary service staff are required to have a minimum of three (3) years of experience treating HIV patients or to have served a high volume of HIV patients in the past.

- Providers are required to provide nutritional counseling as part of primary care services.

- Providers are required to inform clients as to generally accepted clinical guidelines for HIV+ pregnant women, treatment of AIDS specific illnesses, clients infected with tuberculosis, hepatitis, sexually transmitted diseases, and other priorities identified by the Miami-Dade HIV/AIDS Partnership's Medical Care Subcommittee.

- Providers are required to screen for TB and make necessary referrals for appropriate treatment. In addition, providers are expected to follow Universal Precautions for TB as recommended by the Centers for Disease Control (CDC). Providers are also required to screen for hepatitis, sexually transmitted diseases, and other priorities identified by the Miami-Dade HIV/AIDS Partnership's Medical Care Subcommittee.

c. **Units of Service for Reimbursement:** Providers will be reimbursed for all tests, medical procedures and follow-up contacts to ensure clients' adherence to prescribed treatment plans using the 2004 Medicare Part B Fee Schedule (Participating, Locality 04). Providers will be reimbursed for lab tests and procedures at rates no higher than those found in the Medicare Clinical Diagnostic Laboratory Fee Schedule, dated December 10, 2003. (No multipliers may be applied to these laboratory rates.) Ryan White Title I will not reimburse providers for TB screening or follow-up treatment if the client is eligible to receive these services from any other funding source. For procedures other than lab tests (no multiplier is allowed), providers will be reimbursed at rates no higher than the Medicare "reimbursable" rates times a multiplier of up to 1.0, with the exception of evaluation and management codes for outpatient medical visits and psychiatric visits which will be reimbursed at rates no higher than the Medicare "reimbursable" rates times a multiplier of up to 1.5. Please note that the rates listed in the Medicare Fee Schedule are Medicare "reimbursable" rates and are 67% of Title I "allowable" rates. For example, as stated in the 2004 Medicare Part B Fee Schedule, procedure code 99202 (new patient visit) has a "reimbursable" rate of $51.29 that is 67% of the "allowable" rate $76.94 (not listed in

the Fee Schedule). As such, providers may apply a multiplier of up to 1.5 to the "reimbursable" rates of evaluation and management procedures that are listed in the approved fee schedule to calculate the "allowable" rate for Title I reimbursement **(see Attachments 20 &20a).** It is important to note that the site of service reduction rate must be used for all procedures, tests, visits, etc. that are marked as a site of service reduction. Medical procedures excluded from Medicare may be provided on a supplementary schedule. A flat rate along with a detailed cost justification for each supplemental procedure must be included in the provider's submission to the County. Ryan White Title I will not reimburse providers for TB screening or follow-up treatment if the client is eligible to receive these services from any other funding source.

d. **Units of Service for Reporting:** Providers must report monthly activity according to the recorded number of client visits and unduplicated number of clients served.

e. **Client Eligibility Criteria:** Providers must document that HIV+ clients who receive Title I funded primary care services have a household income that does not exceed 300% of the Federal Poverty Level and are permanent residents of Miami-Dade County. Clients receiving primary care services must be documented as having been properly screened for Medicaid, Medicaid Waiver, Medicare, and other public sector funding (i.e., the Medically Needy Program) as appropriate. While clients qualify for and can access Medicaid, Medicaid Waiver, Medicare, or other public sector funding for primary care services, they will not be eligible for Ryan White Title I funding for these services, except for those diagnostic tests and/or medical procedures excluded by Medicaid, Medicare and other funding sources.

f. **Performance Improvement and Outcome Measures:** Providers will develop performance improvement programs, and collaborate with the Miami-Dade County Title I Performance Improvement Program.

Providers will be measured against the outcome measures contained in **Attachment 28.** They will be responsible for collecting and reporting on certain data to measure performance, as detailed in the attachment. This information will be utilized by the County and the Miami-Dade HIV/AIDS Partnership to evaluate the cost and effectiveness of services rendered to Title I clients, the frequency of service delivery, and the type of procedures or services provided. This information will be reported at a minimum on an annual basis, in a format to be provided by the County.

g. **Licensing/Accreditations:** Service provider sites must possess appropriate occupational licensing by Miami-Dade County and other applicable incorporated areas (i.e., City of Miami, City of Miami Beach, etc.). It is recommended that primary care providers be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Individual caregivers must be licensed by the Florida Department of Business and Professional Regulation within the appropriate professional board (i.e., Physicians, Nurse Practitioners, Registered Nurses, etc.). All physicians must possess a Controlled Substance Registration License (DEA

Certification) for dispensing controlled substances. Individuals providing nutritional counseling must be Registered Dietitians (RD). A Registered Dietitian Eligible (RDE) may provide nutritional counseling under the supervision of a Registered Dietitian.

Outpatient Specialty Care

This service covers short-term ambulatory treatment of specialty medical conditions and associated diagnostic procedures for HIV+ clients, based upon referral from a primary care provider. Specialties may include, but are not limited to, outpatient rehabilitation, dermatology, oncology, optometry, ophthalmology, obstetrics and gynecology, urology, podiatry, pediatrics, rheumatology, physical therapy, occupational therapy, speech therapy, respiratory therapy, developmental assessment and psychiatry. *Note: primary care provided to persons with HIV disease is not considered specialty care. Providers must offer access to a range of specialty services.*

Special consideration will be given to providers who employ persons living with HIV/AIDS (PLWHs or PLWAs) and include them in the provision of service.

a. **Program Operation Requirements:** Proposed programs should target low-income uninsured persons, especially women, children, and homeless individuals. Special emphasis is placed on programs offering ophthalmic care and programs offering gynecological services to non-pregnant women.

   Providers of outpatient specialty care services will be expected to offer and post walk-in hours to ensure maximum accessibility to outpatient medical care.

   Providers of outpatient specialty care services will be expected to offer basic education to clients on various treatment options as it pertains to the specialty service being utilized. Outpatient specialty care providers will be expected to educate clients on the importance of complying with their medication regimen with the objective of reducing the risk of developing further complications and spreading a resistant virus, and to ensure a healthy life for the client. Outpatient specialty care providers are expected to encourage clients to take medications pertaining to specialty care treatment as well as treatment recommendations made by the primary care physician. Frequent contact should be maintained with the primary care physician for results, follow-up and/or re-evaluation, as well as other caregivers (i.e., the client's case manager, nutritionist, home health care nurse, primary care physician, pharmacist, counselor, etc.) and with the client in order to monitor that he/she adheres to his/her medication schedule and other recommendations.

   Outpatient specialty care providers will also be expected to empower clients to be actively involved in the development and monitoring of their treatment and adherence plans, and must ensure that immediate follow-up is available for clients who miss their prescription refills and/or who experience difficulties with adherence in regards to the specialty care service provided. Outpatient specialty care providers

must assist clients with becoming knowledgeable about HIV/AIDS and its relationship to the specialty care service being provided. It is also expected that outpatient specialty care providers will help clients understand the reason for specialty care treatment and will help identify and address the possible factors affecting adherence to recommendations.

Providers of outpatient specialty care services are required to identify a single point of contact for case management and outside agencies who have a client's signed consent and require information.

b. Service Delivery Standards: Providers of this service will adhere to the *Public Health Service Clinical Guidelines for the Treatment of AIDS Specific Illnesses, Title I System-wide Standards of Care* and the *Minimum Primary Medical Care Standards for Chart Review.*

Guidelines: Providers must adhere to the following clinical guidelines for treatment of AIDS specific illnesses:

- Guidelines for the Use of Antiretroviral Agents in HIV-Infected Adults and Adolescents. U.S. Public Health Service, November 10, 2003.
- Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection. U.S. Public Health Service, January 20, 2004.
- U.S. Public Health Service Task Force Recommendations for the Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV-1 Transmission in the United States, November 26, 2003.
- A Guide to the Clinical Care of Women with HIV/ AIDS, Jean Anderson, MD, U.S. Department of Health and Human Services, Health Resources and Services Administration, 2001 First Edition.
- 2001 USPHS/ISDA Guidelines for the Prevention of Opportunistic Infections in Persons Infected with Human Immunodeficiency Virus. U.S. Public Health Service/IDSA, November 28, 2001.
- In addition, providers are encouraged to adhere to other generally accepted clinical practice guidelines.

Standards:

- Specialty care providers or identified key direct specialty service staff are required to be board certified in their area of specialty and are preferred to have HIV experience.

c. **Units of Service for Reimbursement:** Providers will be reimbursed for all tests, medical procedures and follow-up contacts to ensure clients' adherence to prescribed treatment plans using the 2004 Medicare Part B Fee Schedule (Participating, Locality 04). Providers will be reimbursed for lab tests and procedures at rates no higher than those found in the Medicare Clinical Diagnostic Laboratory Fee Schedule, dated December 10, 2003. (No multipliers may be applied to these laboratory rates.) Ryan White Title I will not reimburse providers for TB screening or follow-up treatment if the client is eligible to receive these services from any other funding source. For procedures other than lab tests (no multiplier is allowed), providers will be reimbursed at rates no higher than the Medicare "reimbursable" rates times a multiplier of up to 1.0, with the exception of evaluation and management codes for outpatient medical visits and psychiatric visits which will be reimbursed at rates no higher than the Medicare "reimbursable" rates times a multiplier of up to 1.5. Please note that the rates listed in the Medicare Fee Schedule are Medicare "reimbursable" rates and are 67% of Title I "allowable" rates. For example, as stated in the 2004 Medicare Part B Fee Schedule, procedure code 99202 (new patient visit) has a "reimbursable" rate of $51.29 that is 67% of the "allowable" rate $76.94 (not listed in the Fee Schedule). As such, providers may apply a multiplier of up to 1.5 to the "reimbursable" rates of evaluation and management procedures that are listed in the approved fee schedule to calculate the "allowable" rate for Title I reimbursement (see **Attachments 20 & 20a).** It is important to note that the site of service reduction rate must be used for all procedures, tests, visits, etc. that are marked as a site of service reduction. Medical procedures excluded from Medicare may be provided on a supplementary schedule. A flat rate along with a detailed cost justification for each supplemental procedure must be included in the provider's submission to the County. Ryan White Title I will not reimburse providers for TB screening or follow-up treatment if the client is eligible to receive these services from any other funding source.

d. **Units of Service for Reporting:** Providers must report monthly activity according to the recorded number of client visits and unduplicated number of clients served.

e. **Client Eligibility Criteria:** Providers must document that HIV+ clients who receive Title I funded outpatient specialty care have a Ryan White Title I Certified Referral or documentation that the clients: (1) are permanent residents of Miami-Dade County; and (2) have a household income that does not exceed 300% of the Federal Poverty Level. In order to receive outpatient specialty care services, clients must have a physician's referral indicating a recent medical history. Clients receiving outpatient specialty care must also be documented as having been properly screened for Medicaid, Medicare, or other public sector funding as appropriate. While clients qualify for and can access Medicaid or other public sector funding for outpatient specialty services, they will not be eligible for Ryan White Title I funding for these services, except for those diagnostic tests and/or medical procedures excluded by Medicaid, Medicare, and other funding sources.

Specialty care providers may request additional medical information or tests as necessary for treatment, as well as medical information relevant to the specialty referral.

f. **Performance Improvement and Outcome Measures:** Providers will develop performance improvement programs, and collaborate with the Miami-Dade County Title I Performance Improvement Program.

Providers will be measured against the outcome measures contained in **Attachment 28**. They will be responsible for collecting and reporting on certain data to measure performance, as detailed in the attachment. This information will be utilized by the County and the Miami-Dade HIV/AIDS Partnership to evaluate the cost and effectiveness of services rendered to Title I clients, the frequency of service delivery, and the type of procedures or services provided. This information will be reported at a minimum on an annual basis, in a format to be provided by the County.

g. **Licensing/Accreditations:** Service provider sites must possess appropriate occupational licensing by Miami-Dade County and other applicable incorporated areas (i.e., City of Miami, City of Miami Beach, etc.). It is recommended that outpatient specialty care providers be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Individual caregivers must be licensed by the Florida Department of Business and Professional Regulation within the appropriate professional board (i.e., Physicians, Nurse Practitioners, Registered Nurses, etc.). All physicians must possess a Controlled Substance Registration License (DEA Certification) for dispensing controlled substances.

h. **Minority AIDS Initiative (MAI):** Funding is also available under the MAI for Outpatient Medical Care (Primary & Specialty Care) Services. MAI Outpatient Medical Care Services are identical to standard Title I funded Outpatient Medical Care Services, except that MAI Outpatient Medical Care Services provide culturally sensitive services that target minority communities exclusively.

Title I MAI funds are designated to reduce the HIV related health disparities and improve the health outcomes for HIV infected minorities such as Black/African-Americans (including Haitians), Hispanics, Native Americans, etc. The over-arching purpose of the MAI Initiative is to achieve 100% access to quality care and 0% disparity in health outcomes.

Special consideration will be given to providers who qualify as "Minority Community Based Organizations" by:

1) Having more than 50% of positions on the executive board or governing body filled by persons of the racial/ethnic minority group(s) to be served;

AND

2) Having more than 50% of key management, supervisory, and administrative positions (e.g., executive director, program director, fiscal director) and more than 50% of key service provision positions (e.g., outreach worker, case manager, counselor, group facilitator) filled by persons of the racial/ethnic population(s) to be served.

In addition, per Federal requirements, organizations funded to provide MAI services **MUST** meet the following criteria:

1) Are located in or near to the targeted community they are intending to serve;

2) Have a documented history of providing services to the targeted community(ies) to be served;

3) Have documented linkages to the targeted populations (not just to other service providers), so that they can help close the gap in access to service for highly impacted communities of color; and

4) Provide services in a manner that is culturally and linguistically appropriate.

Providers must clearly specify the target population(s) to be served [i.e., Black/African-American (including Haitians), Hispanic, Native Americans, etc.]. If more than one racial/ethnic group is targeted, the percentage that each group will represent of the total number of clients to be served must be identified.

Outcome Measures / Performance Indicators: MAI Outpatient Medical Care

Providers of MAI Outpatient Medical Care Services will collect information on the specific outcome measures/performance indicator listed below. This information will be utilized by the County and the Miami-Dade HIV/AIDS Partnership to evaluate the cost and effectiveness of services rendered to Title I clients, the frequency of service delivery, and the type of procedures or services provided. This information will be reported at a minimum on an annual basis, in a format to be provided by the County:

1) Unduplicated number of Black/African-American (including Haitians), Hispanic, Native American clients, etc. who have experienced an increase in their CD4 count and a reduction in viral load as a result of their participation in the Title I MAI Outpatient Medical Care program.

i. **Allocation:** Based on the Miami-Dade HIV/AIDS Partnership FY 2004 allocation for Outpatient Medical Care Services, the anticipated (approximate) amount of funds available in this RFP for standard Outpatient Medical Care services (Primary & Specialty Care to the general HIV/AIDS population and to Minority Populations) is **$1,270,122.**

Providers are required to specify as part of their proposal the type of funding that is being requested, either general Title I funding or MAI funding. If both types of funding are requested, the proposal must address the proposed services separately in distinct sections. Proposals must include separate proposed service narratives, budgets, budget justifications, etc., each clearly identifying the type of funding requested. Funds are awarded separately for each type of program (standard Outpatient Medical Care Services and MAI Outpatient Medical Care Services).

II. Prescription Drugs

This service includes the provision of injectable and non-injectable Prescription Drugs, pediatric formulations, and non-prescription nutritional supplements, appetite stimulants, and/or related supplies prescribed or ordered by a physician to prolong life, improve health, or prevent deterioration of health for HIV+ persons who do not have prescription drug coverage and who are ineligible for Medicaid or other public sector funding. This service area also includes assistance for the acquisition of non-Medicaid reimbursable drugs, as well as the purchase of consumable medical supplies and durable medical equipment that are required to administer prescribed medications.

Special consideration will be given to providers who employ persons living with HIV/AIDS (PLWHs or PLWAs) and include them in the provision of service.

a. **Program Operation Requirements:** Providers are required to provide county-wide delivery, and must specify provisions for home delivery of medications and related supplies and equipment for eligible Title I clients who require this service.

   Contracts will further stipulate that the provision of this service may not be limited to an agency's own clients, that the service provider must be linked to an existing case management system through agreements with multiple case management providers, that a Title I Certified Referral **(Attachment 34)** and a Title I Intake Form **(Attachment 30)** must be completed by a case manager and must be attached to the prescription presented by the client or a designee. The Certified Referral Form must include a client ID number traceable to the case management agency initiating the referral and a client CIS number assigned by the Title I Service Delivery Information System. This case management agency would be responsible for collecting and reporting all required documentation and demographic information. Providers will be contractually required to enter into formal referral agreements that will detail responsibilities of both parties and penalties for not complying with the referral agreement.

   Providers of prescription drugs services will be expected to educate clients on the importance of complying with their medication regimen with the objectives of reducing the risk of developing and spreading a resistant virus, and to ensure a healthy life for the client. In addition, providers of prescription drugs will be expected to offer basic education to clients on various treatment options, including

information about state of the art combination drug therapies. Furthermore, clients must be encouraged to take medications as prescribed, as well as to follow the recommendations made by physicians, nutritionists, and therapists regarding medication management. Frequent contact must be maintained with other caregivers (i.e., the client's case manager, physician, nutritionist, home health care nurse, counselor, etc.) and with the client in order to monitor that he/she adheres to his/her medication schedule and ensure that the client receives coordinated, interdisciplinary support for adherence and assistance in overcoming barriers to meeting treatment objectives. Additionally, prescription drugs providers will be expected to immediately inform case managers when clients are not meeting their medication regimen (i.e., the client misses prescription refills or is having any other difficulties with adhering to the prescribed treatment).

Providers of prescription drugs services will also be expected to empower clients to be actively involved in the development and monitoring of their treatment and adherence plans, and must ensure that immediate follow-up is available for clients who miss their prescription refills and/or who experience difficulties with adherence. Prescription drugs providers must ensure that the client understands adherence and resistance concepts; understands the reason for treatment; identifies and addresses the possible factors affecting adherence; successfully runs trials with colored candies or other similar methods, if needed; and, understands their treatment schedule.

b. Service Delivery Standards: Providers of this service will adhere to the *Title I System-wide Standards of Care.*

c. Units of Service for Reimbursement: Due to anticipated changes in the drug pricing structure utilized by the County for the provision of this service, providers are required to develop and propose two (2) different unit costs for this service, utilizing the following methodologies:

NOTE: THE CURRENT REIMBURSEMENT STRUCTURE IS BASED ON AWP PRICING. PROVIDERS WILL BE NOTIFIED IN WRITING WHEN THE REIMBURSEMENT STRUCTURE IS CHANGED TO PHS PRICING.

1) Providers will be reimbursed for prescription drugs, including protease inhibitors, based on the Average Wholesale Price (AWP) of the prescription provided to the Title I patient, minus a per-prescription discount rate. Total costs should include the cost of home delivery. Providers must stipulate the discount rate that they will be subtracting from the AWP, which may not be less than 7%. Please note that providers may utilize a discount rate higher than 7% (i.e., AWP - 10%). (For example, if the AWP of a prescription for Indinavir is $100, and your proposed discount rate is 10%, then the straight rate is equal to $90.00.) An estimate of the number of patients (unduplicated caseload) expected to receive these services must be included on the price form **(Attachment 21).**

2) Providers will be reimbursed for prescription drugs, including protease inhibitors, based on the Public Health Services (PHS) price of the prescription provided to the Title I patient, plus a flat dispensing fee. Total costs should include the cost of home delivery and other direct costs associated with the provision of this service. Providers must stipulate a flat rate that will be added to the PHS price. (For example, if the PHS of a prescription for Indinavir is $50, and your proposed flat rate is $5.00 then the straight rate is equal to $55.00.) An estimate of the number of patients (unduplicated caseload) expected to receive these services must be included on the price form **(Attachment 21a).**

3) Providers will be reimbursed for consumable medical supplies and durable medical equipment necessary for the administration of medications based on rates not to exceed 2004 Medicare Part B Fee Schedule (Participating, Locality 04) rates times a multiplier of up to 1.10. In the absence of an existing Medicare rate, reimbursement for consumable medical supplies and durable medical equipment necessary for the administration of medications will be based on rates not to exceed Medicaid's Durable Medical Equipment/Medical Supply Services Coverage and Limitations Handbook (effective March 2003) rates times a multiplier of up to 1.5. Equipment and supplies excluded from Medicare and Medicaid may be provided on a supplementary schedule **(Attachment 21n).**

d. Units of Service for Reporting: Providers must report monthly activities in terms of the individual drugs dispensed (utilizing federally assigned codes to be provided by the County), the number of prescriptions filled for each drug, the amount of Title I funds spent dispensing each drug, and the unduplicated number of clients that received each drug listed in the Ryan White Title I Prescription Drugs Formulary.

Provider monthly reports for durable medical equipment and supplies must include the number of patients served, equipment and medical supplies distributions per patient, and dollar amounts per patient. Providers must also submit to the County a list of the equipment and medical supplies that will be available to the HIV+ client. This list must identify each piece of equipment and medical supplies using the State of Florida Medicaid Codes. Providers may submit a supplemental list for items that are not identified by Medicaid.

e. Client Eligibility Criteria: Providers must document that HIV+ clients who receive Title I funded prescription drugs services: (1) are permanent residents of Miami-Dade County; (2) have a household income that does not exceed 300% of the Federal Poverty Level, and (3) have a physician's referral or prescription for this service. Clients receiving prescription drugs services must be documented as having been properly screened for the State AIDS Drugs Assistance Program (ADAP), Medicaid, or other public sector funding (e.g., the Medically Needy Program) as appropriate. While clients qualify for and can access other public funding for prescription drugs, they will not be eligible for Ryan White Title I

funding for this service, unless the prescription drug needed by the client is not covered by the funding source.

f. **Performance Improvement and Outcome Measures:** Providers will develop performance improvement programs, and collaborate with the Miami-Dade County Title I Performance Improvement Program.

Providers will be measured against the outcome measures contained in **Attachment 28**. They will be responsible for collecting and reporting on certain data to measure performance, as detailed in the attachment. This information will be utilized by the County and the Miami-Dade HIV/AIDS Partnership to evaluate the cost and effectiveness of services rendered to Title I clients, the frequency of service delivery, and the type of procedures or services provided. This information will be reported at a minimum on an annual basis, in a format to be provided by the County:

g. **Ryan White Title I Prescription Drugs Formulary:** Ryan White Title I funds may only be used to purchase or provide vitamins, nutritional supplements, appetite stimulants, and/or other prescriptions to HIV/AIDS patients as follows:

(1) Prescribed medications that are included in the most recent release of the Ryan White Title I Prescription Drugs Formulary (**Attachment 21b**);

(2) Medications, nutritional supplements, appetite stimulants or vitamins that have been prescribed for the patient by his/her physician;

(3) A Title I Letter of Medical Necessity, completed by a physician, has been submitted for any nutritional supplements. The client must also have the Title I Letter of Medical Necessity signed by a Registered Dietitian/Nutritionist for nutritional supplements as indicated in the most recent release of the Title I Prescription Drugs Formulary (**Attachment 21c**);

(4) A Title I Letter of Medical Necessity, completed by a physician, has been submitted for Testosterone Gel (Androgel 1%) **(Attachment 21d);**

(5) A Title I Letter of Medical Necessity, completed by a physician, has been submitted for Antiretroviral Resistance Assay **(Attachment 21e);**

(6) A Title I Letter of Medical Necessity, completed by a physician, has been submitted for Sporanox **(Attachment 21f);**

(7) A Title I Letter of Medical Necessity, completed by a physician, has been

submitted for Valacyclovir (new prescriptions) **(Attachment 21g);**

(8) A Title I Letter of Medical Necessity, completed by a Board certified gastroenterologist, has been submitted for Pantoprazole **(Attachment 21h);**

(9) A Title I Letter of Medical Necessity, completed by a physician, has been submitted for Olanzapine (Zyprexa) **(Attachment 21i);**

(10) A Title I Letter of Medical Necessity, completed by a physician, has been submitted for Durable Medical Equipment and Supplies (as needed for the administration of medications only) **(Attachment 21j);**

(11) A Title I Letter of Medical Necessity, completed by a physician, has been submitted for Appetite Stimulant (Attachment 21k);

(12) A Prior Authorization Form, completed by a physician, for Procrit **(Attachment 21l);**

(13) A Prior Authorization Form, completed by a physician, for Neupogen **(Attachment 21m);**

(14) Providers must comply with any restrictions listed in the Title I Prescription Drugs Formulary. This formulary is subject to periodic revision.

h. **Miami-Dade County Public Health Medications (State of Florida AIDS Drug Assistance Program – ADAP):** Ryan White Title I funds may not be used to purchase medications available free of charge from the Miami-Dade County Health Department to clients who qualify for and can access this service.

i. **Ryan White Title I funds** may not be used to pay for the delivery of medications, durable medical equipment or medical supplies unless one of the following conditions is met by the client and is documented by the client's physician:

The client is disabled or has AIDS, as defined by the CDC (condition is permanently valid);

The client has been examined and found to be suffering from an illness that

significantly limits his/her capacity to travel (condition is valid for the period indicated by the physician or for thirty (30) days from the date of certification);

The client's case manager has documented the need for home delivery and has requested that delivery be provided to the client;

The client is a minor (under 18 years of age) or the caregiver of a minor (condition is valid until the child's eighteenth birthday or until the death of the child, if the client is the caregiver).

j. **Licensing/Accreditations:** Service provider sites must possess appropriate occupational licensing from Miami-Dade County and other applicable incorporated areas (i.e., City of Miami, City of Miami Beach, etc.). All Title I funded pharmacists must be registered pharmacists with the Florida Department of Business and Professional Regulation. In addition, pharmacists must possess a Controlled Substance Registration License (DEA Certification).

k. **Allocation:** Based on the Miami-Dade HIV/AIDS Partnership's FY 2004 allocation for Prescription Drugs, the anticipated (approximate) amount of funds available for this service category in this RFP is **$224,105).**

III. Case Management

The Title I Case Management service category has two (2) distinct components: **Case Management and Peer Education and Support Network (PESN)**. *Providers are required to offer both types of case management services.*

Case management is a client-centered collaborative process that meets an individual's health and support service needs by assessing, planning, implementing, coordinating, monitoring and evaluating available options and services. Case management addresses situational needs and promotes continuity of care for the client. Case management is predicated upon patient empowerment, realized through the identification of client needs and subsequent facilitation of access to appropriate services. Case management addresses both individual and family entities and their needs, and both adults and children.

The purpose and goals of case management are: 1) to coordinate services across funding streams; 2) to reduce service duplication across providers; 3) to assist the client with accessing services; 4) to use available funds and services in the most efficient and effective manner; 5) to increase the client's adherence to the care plan (i.e., medication regimen) through counseling; 6) to empower clients to remain as independent as possible; 7) to improve service outcomes; and 8) to control cost while ensuring that the client's needs are properly addressed.

Special consideration will be given to providers who employ persons living with HIV/AIDS (PLWHs or PLWAs) and include them in the provision of service.

Case Management: Case managers must be knowledgeable about the diversity of programs and able to develop service plans from various funding streams. They are responsible for helping clients access all needed services, not just Ryan White services.

Case managers are responsible for performing the following functions: 1) conducting a full assessment of the client's medical, financial, social, and other needs (initial intake); 2) care planning; 3) managing and coordinating services (referrals, assisting with initial appointments and coordinating services required by the care plan etc.); 4) monitoring client adherence to the care plan and medication regimens, as well as ensuring that service providers involved in the client's care are rendering services as requested; 5) evaluating services provided to the client by all sources to determine consistency with the established care plan; 6) reassessing and revising the care plan; 7) conducting secondary prevention; and 8) coordinating and participating in the provision of permanency planning and counseling on parenting issues.

Peer Education and Support Network (PESN): At the option of the client, the case management agency will assign an HIV+ "Peer" (i.e., PESN, Case Aide, Peer Educator, Peer) to provide "peer support", including client orientation and education about health and social service delivery systems. The PESN Peer Educator may assist with initial client intake, paperwork and applications for financial and medical eligibility, educating new clients on the process and what to expect, as well as physically walking clients through initial appointments for medical care and other entitlements. The Peer may accompany clients to and from medical appointments, as needed.

The Peer will also have basic knowledge of HIV/AIDS services and receive necessary training on HIV funding streams.

As incentives for productivity, providers are encouraged to provide the Peer with educational opportunities, as well as a standard living wage and medical benefits under contractual agreement with the County.

If the client decides not to access the PESN, then the case manager will also be responsible for providing the following services: 1) the presentation of information regarding the HIV service delivery system across funding streams, and 2) assistance to clients in preparing applications for other benefit programs.

The following requirements apply to both Case Management and PESN services (including Minority AIDS Initiative) as indicated:

a. **Program Operation Requirements:** Providers must ensure that case management services include, at a minimum, the following: peer support, assessment, follow-up, direction of clients through the entire spectrum of health and support services, and facilitation and coordination of services from one service provider to another. Providers of case management services are expected to educate clients on the importance of complying with their medication, consistent with the Title I Case Management Handbook.

Case managers must maintain frequent contact with other providers (the client's physician, nutritionist, home health nurse, pharmacist, counselor, etc.) and with the client to help him/her adhere to medication regimens and ensure that the client receives coordinated, interdisciplinary support for adherence and assistance in overcoming barriers to meeting treatment objectives.

Case management providers are expected to empower clients to be actively involved in the development and monitoring of their treatment and adherence plans, and to ensure that immediate follow-up is available for clients who miss their prescription refills and/or who experience difficulties with adherence. Case Management providers must ensure that the client is knowledgeable about HIV/AIDS; understands CD4 count, viral load, adherence and resistance concepts; understands the reason for treatment; identifies and addresses the possible factors affecting adherence; and understands his/her treatment schedule to the best of the client's ability.

1. Case Manager Qualifications:

Providers of this service will adhere to the educational and training requirements of staff as detailed in the *Ryan White Title I System-wide Standards of Care* and the *Coordinated Case Management Standards of Service.*

2. Provider Requirements:

a) Contractual. Providers will be expected to document in scope of services appearing in the Title I contract with Miami-Dade County the following:

- An explanation of the training that will be offered to case management staff, including "peers," and should include cultural sensitivity issues.
- An explanation of how client's adherence to treatment will be monitored and how adherence problems will be identified and resolved;
- An explanation of how the provider will serve clients who speak English, Spanish, and Creole or who have limited language proficiency. **Case management providers must budget for the following expenses or otherwise accommodate client needs for: American Sign Language interpreter, translator, Braille, and other materials to accommodate clients with limited English language proficiency.**
- A description of linkage agreements in place with other HIV/AIDS service providers.

b) Required Forms. Case management staff will utilize the Ryan White Title I standardized forms for all case management functions as developed by the

Miami-Dade HIV/AIDS Partnership and the County.

c) ***Referrals.*** All referrals to Title I services must be made utilizing the Ryan White Title I Certified Referral Form (**Attachment 34**). Referrals cannot be made for services not documented in the client's needs assessment and care plan. However, in the case of emergency, care plans may be amended within one business day to allow for the referral. Referrals for non-Title I services will use the general referral form available in the Title I Service Delivery Information System (SDIS).

d) ***Caseload.*** Case managers should have a caseload of no more than 70 clients. Clients limited to only "situational needs" do not need to be included in the caseload count.

e) ***Peer schedules.*** Providers are reminded that some "peer" workers may be eligible for disability income and/or other supplemental income; consequently, a part-time working schedule should be well-planned to meet the needs and benefits of the employee.

b. Service Delivery Standards: Providers of this service will adhere to the *Title I System-wide Standards of Care* and to the *Title I Coordinated Case Management Standards of Service.*

c. Units of Service for Reimbursement: The units of service used for Case Management and PESN reimbursements are as follows **(Attachments 22 – 22c):**

1. Case Management Services

- *Face-to-Face encounter*: quarter-hour units (15 minutes), at rates not to exceed $12.50 per unit, defined as any time the case manager has direct contact with the client in person. In consultations with a child and one or more adults, encounters are billed for one HIV positive member only.

- *Other encounter:* quarter-hour units, at rates not to exceed $ 12.50 per unit, defined as any non-face-to-face contact with (or on behalf of) the client, including telephone contacts with the client and/or his/her representatives, development of a care plan, travel time (with documentation in the client file of reason for travel), follow-up contacts with the client or other providers to ensure adherence to a prescribed treatment plan, contacts with other providers or representatives on behalf of the client, referral activities (setting up appointments, arranging transportation, etc.), or intramural treatment planning meetings held on behalf of a client.

2. Peer Education and Support Network (PESN) Services

- *Face-to-Face encounter*: quarter-hour units, at rates not to exceed $6.25 per unit, defined as any time the "Peer" has direct contact with the client in person.

- *Other encounter:* quarter-hour units (15 minutes), at rates not to exceed $6.25 per unit, defined as any non-face-to-face contact with (or on behalf of) the client, including telephone contacts with the client and/or his/her representatives, travel time (with documentation in the client file of reason for travel), follow-up contacts with the client or other providers to ensure adherence to a prescribed treatment plan, or contacts with other providers or representatives on behalf of the client.

3. Providers are required to document in the client's file each unit of service performed (including the time spent) as face-to-face encounters or on behalf of a client. Units of service must be documented and reported separately for PESN and case management services.

4. Client eligibility screening for voucherable services is billable as a unit of service depending on the amount of time spent with the client. However, case managers may not distribute vouchers, with the exception of transportation vouchers. Costs related to the distribution of voucher services should be covered under the dispensing charge allowed for handling of vouchers under each respective voucherable service category.

d. Units of Service for Reporting: Providers of PESN and general Case Management services must report, separately, their monthly activities according to quarter-hour (15 minutes) "Face-to-Face" encounters and quarter-hour (15 minutes) "Other" encounters. In addition, providers must report the number of unduplicated clients served.

e. Eligibility Criteria: Providers must document that clients receiving Title I funded PESN and case management services: (1) are permanent residents of Miami-Dade County; (2) are HIV+ asymptomatic, HIV+ symptomatic, or have AIDS (as defined by the CDC), and (3) have a household income that does not exceed 300% of the Federal Poverty Level. All clients must be properly screened for Medicaid, Medicaid Waiver, and other public sector funding (i.e., the Medically Needy Program), as appropriate. While clients qualify for and can access Medicaid, Medicaid Waiver, or other public sector funding for case management services, they will not be eligible for Ryan White Title I funding for these services.

f. Performance Improvement and Outcome Measures: Providers will develop performance improvement programs, and collaborate with the Miami-Dade County Title I Performance Improvement Program.

Providers will be measured against the outcome measures contained in **Attachment 28**. They will be responsible for collecting and reporting on certain data to measure performance, as detailed in the attachment. This information will be utilized by the

County and the Miami-Dade HIV/AIDS Partnership to evaluate the cost and effectiveness of services rendered to Title I clients, the frequency of service delivery, and the type of procedures or services provided. This information will be reported at a minimum on an annual basis, in a format to be provided by the County:

g. **Minority AIDS Initiative (MAI):** Funding is also available under the MAI for Case Management Services. MAI Case Management Services are identical to standard Title I funded Case Management Services, except that MAI Case M anagement Services provide culturally sensitive services that target minority communities exclusively.

Title I MAI funds are designated to reduce the HIV related health disparities and improve the health outcomes for HIV infected minorities such as Black/African-Americans (including Haitians), Hispanics, Native Americans, etc. The over-arching purpose of the MAI Initiative is to achieve 100% access to quality care and 0% disparity in health outcomes.

Special consideration will be given to providers who qualify as "Minority Community Based Organizations" by:

1) Having more than 50% of positions on the executive board or governing body filled by persons of the racial/ethnic minority group(s) to be served;

AND

2) Having more than 50% of key management, supervisory, and administrative positions (e.g., executive director, program director, fiscal director) and more than 50% of key service provision positions (e.g., outreach worker, case manager, counselor, group facilitator) filled by persons of the racial/ethnic population(s) to be served.

In addition, per Federal requirements, organizations funded to provide MAI services **MUST** meet the following criteria:

1) Are located in or near to the targeted community they are intending to serve;

2) Have a documented history of providing services to the targeted community(ies) to be served;

3) Have documented linkages to the targeted populations (not just to other service providers), so that they can help close the gap in access to service for highly impacted communities of color; and

4) Provide services in a manner that is culturally and linguistically appropriate.

Providers must clearly specify the target population(s) to be served [i.e., Black/African-American (including Haitians), Hispanic, Native Americans, etc.].

If more than one racial/ethnic group is targeted, the percentage that each group will represent of the total number of clients to be served must be identified.

Outcome Measures / Performance Indicators: MAI Case Management & PESN Program

Providers of MAI Case Management and PESN Services will collect information on the specific outcome measures/performance indicators listed below. This information will be utilized by the County and the Miami-Dade HIV/AIDS Partnership to evaluate the cost and effectiveness of services rendered to Title I clients, the frequency of service delivery, and the type of procedures or services provided. This information will be reported at a minimum on an annual basis, in a format to be provided by the County:

1) Unduplicated number of Black/African-American (including Haitians), Hispanic, Native American clients, etc. who are receiving coordinated medical and prescription drug treatment as a result of the Title I MAI Case Management program efforts, and who have experienced an increase in their CD4 count and a reduction in viral load.

h. Licensing/Accreditations: All provider sites must possess appropriate occupational licensing from Miami-Dade County and other applicable incorporated areas (i.e., City of Miami, City of Miami Beach).

i. Allocation: Based on the Miami-Dade HIV/AIDS Partnership FY 2004 allocation for Case Management Service programs, the anticipated (approximate) amount of funds available in this RFP for standard Case Management services (general HIV/AIDS population and minority populations) is **$564,4980.**

Providers are required to specify as part of their proposal the type of funding that is being requested, either general Title I funding or MAI funding. If both types of funding are requested, the proposal must address the proposed services separately in distinct sections. Proposals must include separate proposed service narratives, budgets, budget justifications, etc., each clearly identifying the type of funding requested. Funds are awarded separately for each type of program (standard Case Management services and MAI Case Management services).

IV. Substance Abuse Counseling - Residential

Services must be provided to HIV/AIDS clients in state licensed treatment facilities, and should be limited to the pre-treatment program of recovery readiness and relapse, as well as harm reduction, conflict resolution, anger management, relapse prevention, family group and intensive counseling to reduce depression, anxiety and other related disorders, drug-free treatment and treatment for alcohol and other drug addictions.

Residential substance abuse treatment provides room and board, substance abuse treatment and counseling, including specific HIV counseling, in a secure, drug-free state-licensed residential (non-hospital) substance abuse treatment facility, and, when necessary, detoxification. Title I funds may not be used for hospital inpatient detoxification.

Special consideration will be given to providers who employ persons living with HIV/AIDS (PLWHs or PLWAs) and include them in the provision of service.

Residential Treatment programs shall comply with the following requirements:

a. **Program Operation Requirements:** Special emphasis is placed on programs that provide services that are highly accessible to target populations.

   Special emphasis is placed on programs that can demonstrate linkages with other services relevant to the needs of people in substance abuse treatment programs.

   Service must be provided in settings that foster the client's sense of self-control, dignity, responsibility for his/her own actions; relief of anxiety and mutual aid are preferred.

   Substance abuse counseling services may be provided to members of a client's family in an outpatient setting if the HIV/AIDS client is also being served. Special consideration will be given to programs offering services to families without separating the family unit. If the client is participating in a residential treatment program the client's family member may visit the facility and participate in the counseling sessions, but the family member may not physically live in residential treatment with the client during the treatment process. A family member's participation in the substance abuse counseling sessions is included in the per day cost charged to Title I (maximum of $100 per day). *Note: For the purpose of this service, family members are defined as those individuals living in the same household as the client.*

   Individual treatment plans must be documented in the client's file and linked to the provision of primary care.

   Providers must ensure that clients adhere to their treatment plan, including prescription drugs regimen.

   Providers of substance abuse treatment must offer flexible schedules that accommodate nutritional needs in order to facilitate clients' compliance with medication regimens.

   Residential substance abuse providers must coordinate billing so that outpatient counseling services provided as a result of a referral by a residential facility are only

reimbursed once as part of the outpatient facility's billing.

Providers are expected to adhere to super-confidentiality procedures. Providers must include their organization's definition of confidentiality, staff confidentiality training, and procedures for maintaining confidentiality.

Providers should demonstrate linkages with other services relevant to the needs of people in substance abuse treatment programs.

Providers must participate in external quality assurance reviews, utilizing a standardized tool as developed by the Miami-Dade HIV/AIDS Partnership.

b. **Service Delivery Standards:** Providers of this service will adhere to the *Title I System-wide Standards of Care.* In addition, providers will be required to demonstrate that they will adhere to generally accepted clinical guidelines for substance abuse treatment of persons with HIV/AIDS.

Guidelines:

- Providers of this service will be required to demonstrate that they will adhere to generally accepted clinical guidelines for substance abuse treatment of persons with HIV/AIDS. The following are examples of such guidelines:

- Published by the American Society of Addiction Medicine (ASAM), these guidelines include principles for working with HIV-positive patients in addiction treatment settings including, but not limited to, post-exposure prophylaxis (PEP) for HIV, integrating HIV-positive patients into addiction treatment programs and groups, neuro-psychiatric components of HIV/AIDS, approaching the medical evaluation in the era of HIV/AIDS, harm reduction strategies in addiction, precautions for caregivers and HIV-infected individuals, pre- and post-test counseling and miscellaneous social and legal aspects relevant to this service population (*Guidelines for HIV Infection and AIDS in Addiction Treatment,* American Society of Addiction Medicine, Chevy Chase, MD, 1998). ASAM has also developed national guidelines for the implementation of a patient placement system. The purpose of this clinical guide is to place the patient in a level of care that has the appropriate resources to treat the patient's condition [*ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders (ASAM PPC-2R)*, American Society of Addiction Medicine, Washington, DC, Second Edition-Revised (April 2001)].

- Rules governing the treatment of physically drug dependent newborns, substance exposed children, and/or children adversely affected by alcohol and the families of these children that are consistent with the administrative regulations promulgated in Chapter 65 of the Florida Administrative Code by the State of Florida Department of Children and Family Services, as may be amended.

- Rules governing the provision of substance abuse treatment services consistent with the regulations promulgated by the State of Florida's Alcohol Prevention and Treatment (APT) and Drug Abuse Treatment and Prevention (DATAP) programs, as may be amended.

- Published by the American Society of Addiction Medicine (ASAM), these guidelines include principles for treatment and housing, precautions for caregivers and HIV-infected individuals, pre and post-test counseling and miscellaneous social and legal aspects relevant to this service population. ASAM has also developed national guidelines for the implementation of a patient placement system. The purpose of this clinical guide is to place the patient in a level of care that has the appropriate resources to treat the patient's condition. [*Guidelines for HIV Infection and AIDS in Addiction Treatment,* American Society of Addiction Medicine, Chevy Chase, MD, 1998; *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders (ASAM PPC-2R),* American Society of Addiction Medicine, Washington, DC, Second Edition – Revised (April 2001)].

- Rules governing the provision of residential and outpatient substance abuse treatment services with regards to licensure and regulatory standards that are consistent with the administrative regulations promulgated in Chapter 65D-30 of the Florida Administrative Code by the State of Florida Department of Children and Families, as may be amended.

c. **Client Eligibility Criteria:** Providers must document that HIV+ clients receiving Title I substance abuse services - residential are permanent residents of Miami-Dade County, have a household income that does not exceed 300% of the Federal Poverty Level, and have been documented as having been properly screened for Medicaid, Medicaid Waiver, or other public sector funding as appropriate. While clients qualify for Medicaid, Medicaid Waiver, or other public sector funding for substance abuse services, they will not be eligible for Ryan White Title I funding for this service.

d. **Performance Improvement and Outcome Measures:** Providers will develop performance improvement programs, and collaborate with the Miami-Dade County Title I Performance Improvement Program.

Providers will be measured against the outcome measures contained in **Attachment 28**. They will be responsible for collecting and reporting on certain data to measure performance, as detailed in the attachment. This information will be utilized by the County and the Miami-Dade HIV/AIDS Partnership to evaluate the cost and effectiveness of services rendered to Title I clients, the frequency of service delivery,

and the type of procedures or services provided. This information will be reported at a minimum on an annual basis, in a format to be provided by the County:

e. **Units of Service for Reimbursement:** The unit of service for reimbursement of substance abuse counseling - residential treatment is a *patient-day* of care, at a rate not to exceed $100 per day [includes the cost of family member(s) participating in the substance abuse counseling session provided during a day of treatment]. If the provider anticipates that clients may be referred to a separate Title I funded outpatient HIV substance abuse counseling agency, then the cost of such activities should not be included as part of the residential provider's per day rate **(Attachment 23).**

f. **Units of Service for Reporting:** Monthly activity reporting for residential substance abuse treatment is per *patient-day* of care and number of unduplicated clients served.

g. **Linkage/Referrals:** Providers of residential substance abuse treatment must document the progress of each patient's care through the treatment program, maintain linkages with one or more outpatient facilities and appropriate community services, including 12-step programs, and be able to refer or place clients in an outpatient program, in collaboration with the patient's case manager and primary care physician, when that is found to be appropriate. Providers are required to determine if the client is currently receiving case management services; if not, the provider must seek enrollment of the client in a case management program while the client is still receiving substance abuse treatment/counseling. A linkage agreement with the case management provider must be established in order to ensure coordination of services while the client remains in treatment. *Note:* referrals to outpatient counseling facilities should only occur when there is a need for HIV specific counseling not offered by the residential facility.

h. **Licensing/Accreditations:** Provider sites must be licensed by the Florida Department of Health as a Residential Substance Abuse Treatment facility. If food is prepared on site, the facility must have a food service license from the Miami-Dade County Health Department. All caregivers providing direct counseling services must possess *postgraduate degrees* in the appropriate counseling-related field, or be a *certified addiction professional* (CAP).

i. **Allocation:** Based on the Miami-Dade HIV/AIDS Partnership's FY 2004 allocation for Substance Abuse Counseling - Residential services, the anticipated (approximate) amount of funds available for this service category in this RFP is **$282,249**.

V. Outreach Services

Outreach services target clients in need of assistance accessing HIV treatment who are:

- Newly diagnosed with HIV/AIDS, not receiving medical care
- HIV+, formerly in care, currently not receiving medical care (lost to care)
- Believed to be HIV+

Outreach services to people already identified as HIV positive consists of activities to introduce them to the system of care and assist them in accessing that system. Outreach includes an initial encounter to identify whether the person is currently receiving health care and support services. For high-risk people not known to be HIV positive, a referral should be made to a testing site to determine if the client is HIV positive.

Once the client is determined to be HIV positive, a referral must be made to a case management agency, medical provider or, if necessary, to a substance abuse treatment facility. The outreach worker may accompany the person to the point of entry into the system and assist in obtaining necessary documentation to receive services. Referrals must be followed up to insure that the client is enrolled in care.

a. Targeted Outreach

Providers must conduct targeted outreach, meaning outreach workers must work with key points of entry. Targeted outreach involves the establishment of formal relationships between providers and key points of entry.

1. Key points of entry include the following:

    - STD clinics
    - counseling and testing sites
    - blood banks
    - hospitals
    - substance abuse treatment providers
    - mental health clinics
    - adult and juvenile detention centers
    - Community Jail Linkage Coalition
    - homeless shelters

2. Linkage agreements form the basis of the formal relationships between providers. Outreach providers must have formal referral and linkage agreements with one or more of the key points of entry to the system of care listed above.

b. Street Outreach

This outreach should be directed to populations known through, for example, local needs assessment data, local epidemiological data, or through review of service data, to be at disproportionate risk for HIV infection.

1. **Use of objective data.** Providers conducting street outreach must target known high-risk areas, venues where significant numbers of people can be found who are believed to be HIV positive. In addition, workers must conduct street outreach during hours when the targeted groups are likely to be on the streets.

2. **Outreach to people lost to care.** Outreach workers may work with service providers to locate people lost to care and bring them back to care. There must be clear documentation from case management or primary care of repeated attempts to contact the client by phone and mail without success. The case manager or practitioner is responsible for attempting contact with his or her client. If contact is not possible and the client appears to have fallen out of care, the case manager or practitioner may refer the case to an outreach worker, there must be clear documentation of attempts to contact and why the case is being referred to an outreach worker.

c. Outreach Activities

1. Outreach workers may engage in the following activities:
   - conduct brief intakes for new clients
   - review data in the Title I Service Delivery Information System (SDIS) for existing clients
   - assess risk behaviors
   - accompany newly discovered clients to the doctor, case manager or substance abuse provider for the purpose of enrolling them in service for the first time or to reconnect to care, or to collect documentation until successful engagement occurs
   - assist client to obtain necessary documentation for entry into the service system
   - make home visits if necessary to meet a client and accompany them to a first visit
   - accompany any client to testing or until successful engagement occurs
   - provide HIV education related services (i.e., education on available treatment options and services available to HIV+ individuals) if directly linked to increasing access of the target population to existing HIV/AIDS service programs
   - In the event that outreach workers spend more than 2½ hours (10 units of service) on these activities, it must be thoroughly documented and submitted to the County for approval.

2. **Inappropriate Outreach Activity. Funds awarded under Title I of the Ryan White CARE Act may not be used for outreach programs that exclusively promote HIV counseling and testing and/or that have as their purpose HIV prevention education. Additionally, broad-scope awareness activities about HIV services that target the general public (i.e., poster campaigns for displays on public transit, TV or radio public service announcements, etc.) may not be funded.**

3. **Documentation.** All outreach workers must maintain documentation which includes the following:

   - name of outreach worker
   - description of any encounter with a client and/or work done on behalf of the client
   - the date and time of the encounter
   - type of encounter (i.e., telephone, person to person, travel)

- name and signature of client
- client's date of birth
- client's gender
- client's race and ethnicity
- client's address or follow-up information

- site where client was identified (i.e., a specific geographic region and/or key point of entry into the system of care)
- time spent on the encounter in minutes
- total units documented
- referral to a testing site to determine if the client is HIV+
- document "initial contact" and "follow-up" contacts, receipt or non-receipt of lab results
- if lost to care, who requested the outreach
- once the client is determined to be HIV+, a referral must be made to a case management agency and/or medical provider
- indicate risk behavior and if street encounter, outreach worker's reason for approaching particular individual
- if the client's condition requires it, the outreach worker should also refer to a substance abuse treatment facility
- referrals must be followed up to insure that the client is enrolled in care
- Final disposition of the client must be documented including whether or not the client was connected to care (i.e., referral was made, client was taken to a medical, case management or substance abuse provider, etc.)

Outreach Worker Incentives, Program Operation Requirements, and Staff Training Requirements

As incentives for productivity, providers are encouraged to provide outreach workers with educational opportunities, as well as a standard living wage and medical benefits as required by contractual agreement with the County.

a. Program Operation Requirements:

1. **Location.** Providers of outreach services must focus their efforts on geographic regions of the county with high incidence of HIV infection and clearly identified unmet needs.

2. **Staff Training.** Outreach workers must attend a minimum of 40 hours of training approved by the county. In addition, all staff providing outreach services must be certified through the state of Florida's Department of Health HIV/AIDS 104, 500, and 501 courses, as well as Orasure training courses or equivalent counseling and testing curricula. Outreach workers must also receive training related to Limited English Proficiency (LEP) and detox programs. Outreach

workers must attend periodic training provided by the Ryan White Title I program.

Outreach providers must ensure that outreach workers are knowledgeable about various resources and providers of medical care, substance abuse treatment, case management and other support services. At a minimum, the outreach provider should have reference material on hand which provides intake requirements, services offered, hours of operation, and contact personnel.

3. **Hours.** Outreach services must be offered during non-traditional business hours at least 25 hours per week.

4. **Cultural Sensitivity.** Providers are encouraged to be creative in developing outreach programs that are culturally sensitive and that meet the specific needs of the identified target sub-populations (i.e., substance abusers, illiterate persons, hard of hearing, etc.). It is desirable that outreach workers reflect the community in which they are working. Special consideration will be given to providers that utilize peer models and indigenous workers in the community.

5. **Employment of PLWHs or PLWAs.** Special consideration will be given to providers who employ persons living with HIV/AIDS (PLWHs or PLWAs) in at least 50% of their outreach worker staff positions.

6. **Documentation**. Providers are required to document in the client's file each unit of outreach service performed (including the time spent) as a face-to-face encounter, telephone contact or referral activity on behalf of a client.

6. **Connection to Care.** Providers are expected to demonstrate that at least 3 percent of people contacted and billed for are actually brought into care.

b. **Service Delivery Standards**: Providers must adhere to the Ryan White Title I System-wide Standards of Care. Providers must participate in external quality assurance reviews, utilizing a standardized tool as approved by the Miami-Dade HIV/AIDS Partnership.

c. Units of Service for Reporting: Monthly activity reporting for this service will be on the basis of an outreach contact.

d. **Units of Service for Reimbursement:** Providers will be reimbursed on the basis of a line-item budget for Title I funded outreach services. Outreach services will be paid on the basis of full-time employees (FTE) at a salary to be negotiated between the service provider and the County. Reimbursement of salaries will be based on the approved budget and productivity as recorded by hours spent doing outreach activities, people contacted, their risk factors, and the number of people actually connected to care. All indirect expenses (other than those associated with the delivery of outreach services) are capped at 10%.

This payment method will be evaluated on the basis of productivity, locales used, people contacted and connected to medical care, case management and/or substance abuse treatment.

e. **Client Eligibility Criteria:** Outreach Workers must target outreach activities to connect HIV clients who are newly diagnosed with HIV/AIDS and not receiving medical care, HIV+ formerly in care, currently not receiving care (i.e., lost to care), or those persons who are believed to be HIV+.

f. **Performance Improvement and Outcome Measures:** Providers will develop performance improvement programs, and collaborate with the Miami-Dade County Title I Performance Improvement Program.

Providers will be measured against the outcome measures contained in **Attachment 28.** They will be responsible for collecting and reporting on certain data to measure performance, as detailed in the attachment. This information will be utilized by the County and the Miami-Dade HIV/AIDS Partnership to evaluate the cost and effectiveness of services rendered to Title I clients, the frequency of service delivery, and the type of procedures or services provided. This information will be reported at a minimum on a quarterly basis.

g. **Minority AIDS Initiative (MAI):** Funding is also available under the MAI for outreach services. MAI outreach services are identical to standard Title I funded outreach services, except that MAI outreach services provide culturally sensitive services that exclusively target minority communities.

Title I MAI funds are designated to reduce the HIV related health disparities and improve the health outcomes for HIV infected minorities such as Black/African-Americans (including Haitians), Hispanics, Native Americans, etc. The over-arching purpose of the MAI Initiative is to achieve 100% access to quality care and 0% disparity in health outcomes.

Special consideration will be given to providers who qualify as "Minority Community Based Organizations" by:

1) Having more than 50% of positions on the executive board or governing body filled by persons of the racial/ethnic minority group(s) to be served;

AND

2) Having more than 50% of key management, supervisory, and administrative positions (e.g., executive director, program director, fiscal director) and more than 50% of key service provision positions (e.g., outreach worker, case manager, counselor, group facilitator) filled by persons of the racial/ethnic population(s) to be served.

In addition, per Federal requirements, organizations funded to provide MAI services **MUST** meet the following criteria:

1) Are located in or near to the targeted community they are intending to serve;

2) Have a documented history of providing services to the targeted community(ies) to be served;

3) Have documented linkages to the targeted populations (not just to other service providers), so that they can help close the gap in access to service for highly impacted communities of color; and

4) Provide services in a manner that is culturally and linguistically appropriate.

Providers must clearly specify the target population(s) to be served [i.e., Black/African-American (including Haitians), Hispanic, Native Americans, etc.]. If more than one racial/ethnic group is targeted, the percentage that each group will represent of the total number of clients to be served must be identified.

Performance and Outcome Measures / Indicators: MAI Outreach Services

NOTE: THESE OUTCOME MEASURES /PERFORMANCE INDICATORS ARE UNDER REVIEW AND ARE SUBJECT TO CHANGE.

Providers of MAI Outreach Services will collect information on the specific outcome measures/performance indicators listed below. This information will be utilized by the County and the Miami-Dade HIV/AIDS Partnership to evaluate the cost and effectiveness of services rendered to Title I clients, the frequency of service delivery, and the type of procedures or services provided. This information will be reported at a minimum on an annual basis, in a format to be provided by the County:

1) Unduplicated number of Black/African-American (including Haitians), Hispanic, Native American clients, etc. adhering to medical treatment as a result of Title I MAI outreach efforts.

2) Unduplicated number of Black/African-American (including Haitians), Hispanic, Native American clients, etc. remaining in care as a result of Title I MAI outreach efforts.

h. **Licensing/Accreditations:** Service provider sites must possess appropriate occupational licensing from Miami-Dade County and other applicable incorporated areas (i.e., City of Miami, City of Miami Beach).

i. **Allocation:** Based on the Miami-Dade HIV/AIDS Partnership FY 2004 allocation for Outreach Services, the anticipated (approximate) amount of funds available in this RFP for standard Outreach Services (general HIV/AIDS population and minority populations) is **$167,824**.

Providers are required to specify as part of their proposal the type of funding that is being requested, either general Title I funding or MAI funding. If both types of funding are requested, the proposal must address the proposed services separately in distinct sections. Proposals must include separate proposed service narratives, budgets, budget justifications, etc., each clearly identifying the type of funding requested. Funds are awarded separately for each type of program (standard Outreach Services and MAI Outreach Services).

VI. Health Insurance Services

There are three types of assistance under this service category: **AIDS Insurance Continuation Program, Insurance Deductibles, and Prescription Drugs Co-Payments**.

Special consideration will be given to providers who employ persons living with HIV/AIDS (PLWHs or PLWAs) and include them in the provision of service.

AIDS Insurance Continuation Program

This service provides assistance to clients who already have private health insurance but are not financially able to pay the insurance premiums. This service does not provide new health insurance policies to eligible clients; it allows them to continue with their current insurance carrier. This service does not include coverage of disability or life insurance payments and does not provide assistance with deductibles and/or co-payments. The maximum amount of assistance a client may receive each month is $650. Title I will be able to assist the client in making back payments of premiums as long as the insurance policy has not been terminated. Assistance may also be provided to facilitate conversion of group coverage (i.e., COBRA) to an individual insurance policy. Title I may only be utilized to pay for a dependent's health insurance premium if the dependent meets the eligibility requirements specified below.

Title I supplements the state AICP when the primary funding sources, Title II and Florida General Revenue, exhaust their funds. Title I support depends on the amount allocated to this service. This service description covers only those services paid for by Ryan White Title I funds.

a. **Program Operation Requirements:** Providers may not reimburse clients directly for their premium expense.

Providers are required to inform clients of their rights regarding insurance coverage and to ensure they use their private health insurance to obtain care.

Clients will not be eligible for Title I services if such services are available under their existing health insurance, private or public.

b. **Service Delivery Standards:** Providers of this service will adhere to the *Title I System-wide Standards of Care.*

c. **Units of Service for Reimbursement:** Providers will be reimbursed for dollars expended per insurance premium plus a dispensing rate of $15 per month **(Attachment 24).**

d. **Units of Service for Reporting:** Monthly activity reporting for this service must be in dollars *expended per insurance premium per client.* The service provider must also report the number of unduplicated clients served each month and the dollars spent per client.

e. **Client Eligibility Criteria:** Clients receiving Title I assistance for this service must meet the following eligibility criteria: 1) be permanent residents of Miami-Dade County; 2) be HIV+ asymptomatic, HIV+ symptomatic, or have AIDS (as defined by the CDC); 3) have a household income that does not exceed 300% of the Federal Poverty Level; 4) have liquid assets (cash) that do not exceed $4,500 (or $5,500 if married or a recognized couple); 5) have active health insurance under a group, individual or COBRA policy; and 6) be willing to sign all required forms and provide all requested eligibility information. A complete financial assessment and disclosure are required.

f. **Performance Improvement and Outcome Measures:** Providers will develop performance improvement programs, and collaborate with the Miami-Dade County Title I Performance Improvement Program.

Providers will be measured against the outcome measures contained in **Attachment 28**. They will be responsible for collecting and reporting on certain data to measure performance, as detailed in the attachment.

Insurance Deductibles

a. **Program Operation Requirements:** The goal of this service is to maintain a client's private health insurance coverage, thereby minimizing the client's reliance on the Title I program for services. Under no circumstances shall payment be made directly to recipients of this service. The maximum amount of assistance a client may receive annually is $2,500. Other methods may be proposed to assist clients with the financial resources necessary to cover a client's health insurance deductibles that the client could otherwise not afford.

b. **Service Delivery Standards:** Providers of this service will adhere to the *Title I System-wide Standards of Care.*

c. **Units of Service for Reimbursement:** Providers will be reimbursed for dollars expended *per deductible plus a dispensing rate* **(Attachment 24a).**

d. **Units of Service for Reporting:** Monthly activity reporting for this service must be in dollars expended *per deductible per client.* The service provider must also report the number of unduplicated clients served each month and the dollars spent per client.

e. **Client Eligibility Criteria:** Providers must document that HIV+ clients who receive Title I assistance for payment of insurance deductibles are permanent residents of Miami-Dade County and have a household income that does not exceed 300% of the Federal Poverty Level. While clients qualify for other public funding for insurance deductibles, they will not be eligible for Ryan White Title I funding for this service. A complete financial assessment and disclosure are required.

f. **Performance Improvement and Outcome Measures:** Providers will develop performance improvement programs, and collaborate with the Miami-Dade County Title I Performance Improvement Program.

Providers will be measured against the outcome measures contained in **Attachment 28**. They will be responsible for collecting and reporting on certain data to measure performance, as detailed in the attachment.

Prescription Drugs Co-Insurance and Co-Payments

a. **Program Operation Requirements:** This type of assistance is available to privately insured clients who are required to pay a fee for their medications. The pharmaceutical provider will bill the insurance carrier for a portion of the cost of the prescription plus the dispensing fee and Title I will cover the remaining portion of the cost for clients who meet the eligibility criteria. Assistance for both co-insurance and co-payments is restricted to those medications on the currently approved Ryan White Title I Prescription Drugs Formulary.

b. **Service Delivery Standards:** Providers of this service will adhere to the *Title I System-wide Standards of Care.*

c. **Units of Service for Reimbursement:** Providers will be reimbursed for dollars expended *per co-payment plus a dispensing rate* **(Attachment 24b).**

d. **Units of Service for Reporting:** Monthly activity reporting for this service must be in dollars *per co-payment per client.* The service provider must also report the number of unduplicated clients served each month and the dollars spent per client.

e. **Client Eligibility Criteria**: Providers must document that HIV+ clients who receive Title I assistance for drug co-payments: (1) are permanent residents of Miami-Dade County; 2) have a household income that does not exceed 300% of the Federal Poverty Level, and (3) have a physician's prescription for the drug. While clients qualify for other public funding for drug co-payments, they will not be eligible for Ryan White Title I funding for this service. A complete financial assessment and disclosure are required.

f. **Performance Improvement and Outcome Measures:** Providers will develop performance improvement programs, and collaborate with the Miami-Dade County Title I Performance Improvement Program.

Providers will be measured against the outcome measures contained in **Attachment 28.** They will be responsible for collecting and reporting on certain data to measure performance, as detailed in the attachment.

g. Licensing/Accreditations: Service provider sites must possess appropriate occupational licensing from Miami-Dade County and other applicable incorporated areas (i.e., City of Miami, City of Miami Beach).

h. **Allocation:** Based on the Miami-Dade HIV/AIDS Partnership's FY 2004 combined allocation for Health Insurance Services, the anticipated (approximate) amount of funds available for this service category in this RFP is **$30,513**.

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RYAN WHITE TITLE I STANDARDS OF CARE

The Ryan White Title I System-wide Standards of Care **(Attachment 25)** and, where applicable, the Coordinated Case Management Standards of Service **(Attachment 26)** and the Minimum Primary Care Standards for Chart Review **(Attachment 27)** form the basis for on-going monitoring and evaluation of funded service providers in FY 2004-05 by the Miami-Dade County Office of Strategic Business Management,, Ryan White Title I Program. It is not expected that contracted organizations be in full compliance with these standards at the time of contract execution. It is assumed, however, that the service provider has read and understands the standards, and by signing a contract the provider is agreeing to make every effort to progress towards full compliance with these standards. The County recognizes that progress towards achieving compliance with the standards will differ from one service provider to another, both in terms of rate of progress and substance. Each service provider is asked to set time specific goals for their organization's progress towards compliance with the standards in the form of a work plan. This workplan may be revised, by the provider, throughout the year with the prior written approval of the County.

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SECTION 3.0 PROPOSAL FORMAT

3.1 INSTRUCTIONS TO PROPOSERS

Proposals **MUST** address all of the topics in this section in the sequence outlined in the Proposal Submission Checklist **(Attachment 36)**. Proposals **MUST** contain each of the below enumerated documents, each fully completed, signed, and notarized where required. Proposals submitted which do not include the following items may be deemed non-responsive and may not be considered for contract award. Responses are to be concise and consist only of the answers to the questions posed. Extraneous material or information should not be submitted. Do not exceed the specified page limitations. **All materials are to be submitted on 8 1/2" X 11" paper, neatly typed on one side only, with standard margins and spacing. An un-bound, one-sided original and fifteen (15) unbound copies (a total of 16) of the complete proposal must be received by Friday, May 14, 2004, at 2:00 P.M. (E.S.T.). No late proposal will be accepted.**

3.2 CONTENTS OF PROPOSAL

To be scored and rated as being fully adequate, each proposal must include the following information:

A. Proposal Title Page

Include on the Proposal Title Page **(Attachment 2)** the services to be provided, the amount of funds being requested to provide these services, and the name/contact information for the contract coordinator or program liaison. The original copy of this form **MUST** be signed by an officer of the Proposer(s) who is legally authorized to enter into a contractual relationship in the name of the Proposer(s). The Proposer(s) **MUST** affix the proposing organization's corporate seal to the original copy of this document, and in the absence of a corporate seal this form must be notarized by a Notary Public. The original copy of the proposal **MUST** be clearly marked as such on the Proposal Title Page.

B. Table of Contents

The Table of Contents should outline in sequential order the major areas of the proposal. All pages of the proposal including the attachments **MUST** be clearly and consecutively numbered and keyed to the Table of Contents. Appendices can be numbered differently/separately from the narrative (e.g., A-1), however, each page should be numbered sequentlially (e.g., A-1, A-2, A-3, etc.).

C. Minimum Qualification Requirements

Proposers shall provide documentation that demonstrates their ability to satisfy all of the requirements specified in this RFP under Section 2.0, Scope of Services. Proposers who do not meet the requirements or who fail to provide supporting documentation will not be considered for an award. If a prescribed format or required documentation for the response to minimum qualification requirements (e.g., proof of licensure as stated in Section 3.2, Item F-12) is listed below, Proposers **MUST** submit such documentation.

D. Abstract for the Proposed Services

The abstract(s) must include the ***full, legal*** name of the proposing organization; corporate/tax status of proposing organization (i.e., not-for-profit or for-profit); a brief description of identified service needs/demands and target geographic area/population; the number of clients to be served, the number of units of service to be provided; a brief description of the proposed program and service approach; and a total budget request. **(Limit 1 page per proposed service)**

E. Service Experience (Complete this section once in your agency's proposal and do not exceed 8 pages, not including forms and/or appendices)

1. Describe your organization's general history, including the date when the organization first started providing services. Do not limit your response to past experience in providing Ryan White Title I services. **Organizations proposing to provide Minority AIDS Initiative (MAI) services must document experience in serving the communities of color targeted in their proposal.**

   Identify the corporate/tax status of your organization (not-for-profit or for-profit). Include as **Appendix 1** documentation of corporate/tax status in the name of the proposing organization and subcontractors, if applicable. If documentation of not-for-profit status is not included as part of the proposal, then the proposal will be reviewed as having been submitted by a for-profit entity. In this instance, the proposal would be subject to federal restrictions to contracting with for-profit organizations.

   List the agency's achievements. State the full range of services that your organization currently provides. If your organization is part of a multi-program organization, provide a description of the parent organization and its involvement in the on-going operation of your service programs.

2. Describe the staff's experience providing services, including the length of time that key staff have provided services, especially services to persons living with HIV/AIDS. Describe the organization's qualifications and accreditations reflecting the ability to manage and provide the services requested in this RFP.

3. Indicate whether or not your organization is a Medicaid, Medicaid Waiver, and/or Medicare provider. Indicate whether or not your organization is classified as a Federally Qualified Health Center (FQHC).

4. Indicate the percentage of clients served by your organization who have been identified as Medicaid eligible.

5. Describe your organization's capabilities to respond to special client groups, such as persons with disabilities and special needs, including individuals with a lack of transportation resources. Describe your organization's cultural and linguistic capabilities. **Organizations proposing to provide Minority AIDS Initiative (MAI) services must document the ability to provide services to targeted community(ies) of color in a manner that is culturally and linguistically appropriate.**

6. Describe your organization's client orientation processes, including the familiarization of clients to services offered by the agency and those available in the community at large.

7. Describe your organization's internal client screening processes to determine medical and financial eligibility for Title I services, and for services offered under other benefit programs.

8. Describe your organization's policies and procedures for conducting internal and external referrals; explain all phases of the referral process; include, as **Appendix 2**, a copy of all referral and linkage agreements, letters of commitment or documentation of working relationships with any organization providing HIV/AIDS services. **Organizations proposing to provide Minority AIDS Initiative (MAI) services must document linkages to targeted communities of color (not just to other service providers).**

9. Describe your organization's policies regarding the initiation and update of client files, including updates to case notes, review of client charts by direct service and supervisory staff, frequency of updates to eligibility documentation; explain how your agency will provide receipts to clients for each service rendered.

10. Describe your system for collecting, maintaining, and reporting client level and service delivery data, as well as agency/administrative information. Describe the organization's process for assigning a unique identifier to each client to ensure accurate reporting of unduplicated client load. Describe current client identification format, if one is available. Explain the system that will be utilized to ensure compliance with Miami-Dade/HRSA contractual reporting requirements **(Attachments 29-31).**

11. Submit, as **Appendix 3**, a complete copy of your organization's most current certified audit verifying that the agency is on a sound financial footing and able to implement a funded service on a reimbursement basis. Financial statements do not represent a complete audit. Therefore, if a certified audit is not available, financial statements and detailed plans to comply with contractual audit requirements **MUST** be submitted as part of the proposal.

12. Explain your organization's system for safeguarding the confidentiality of clients, including the organization's definition of confidentiality, policies regarding staff's compliance with confidentiality regulations, the organization's efforts to conduct regular training on confidentiality issues, the protection of client records, exchange and release of information, and the protection of the client's privacy. Furthermore, describe your organization's efforts to comply with the rules and regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), if applicable.

13. Describe the process used to monitor and control the quality of care provided by staff. Describe ongoing staff training activities including your organization's training curriculum, if applicable. If an extensive training curriculum is available, include a copy as an additional appendix.

14. Explain your organization's policies regarding compassionate, courteous, and non-judgmental care to people living with HIV/AIDS, including a description of internal measures used to evaluate and maintain customer service practices.

15. Describe your organization's current grievance procedures, or those proposed to be established for these purposes. Indicate how your organization informs clients and other service providers of its grievance policies, and include, as **Appendix 4**, a copy of these policies.

16. Explain how your organization solicits input from people living with HIV/AIDS in its decision-making processes; indicate whether or not the organization has an established Client Advisory Board.

17. Indicate which Ryan White Title I System-wide Standards of Care **(Attachment 25)** your agency is in full compliance with at the time of proposal submission. Furthermore, identify your agency's proposed timeline for progress towards meeting those System-wide Standards of Care that it is not currently able to meet.

18. Include as part of your proposal a statement that insures that your organization serves all clients without regard to race, color, religious background, ancestry, sex, age, national origin, medical or mental condition.

19. Enclose, as **Appendix 5**, a current listing of the Board of Directors, Officers of the Organization, and Advisory Council Members; provide an ethnic/racial breakdown of the Board members and of the organization's staff (paid or volunteer). **IMPORTANT: This information must be submitted by all proposing organizations, however, it is particularly relevant to proposers of Minority AIDS Initiative (MAI) services since it will be used by the Evaluation/Selection Committee appointed by the County Manager as a criterion when determining if a proposing organization may be given special consideration to receive MAI funds.**

20. Describe any prior or pending litigation, either civil or criminal, involving a governmental agency or which may affect the performance of the services to be rendered herein, in which the proposing organization, any of its employees or subcontractors (subconsultants) is or has been involved within the last three (3) years.

F. Proposed Service(s) (Complete once for each proposed service and do not exceed 8 pages, not including forms and/or appendices)

Carefully review the service definition(s) included in **Section 2.0, SCOPE OF SERVICES.** In your response to this section, describe your proposed service addressing all requirements and restrictions listed in the definition of the service you

propose to provide. **Proposers are reminded that no exceptions may be taken to any requirements specified in the service definitions.**

1. Describe your organization's past experience in providing the proposed service(s), including a description of funding received (i.e., other grants, Medicaid, etc.), and the number of clients served and over what time period. **Organizations proposing to provide Minority AIDS Initiative (MAI) services must document experience in serving the communities of color targeted in their proposal.**

2. If your agency currently provides this service indicate the number of clients served by gender and ethnicity; number and level of staff providing the proposed service(s), and the source(s), amount(s), time period(s) of existing HIV/AIDS related funding; complete a Funding Source Summary Form **(Attachment 33).**

3. Describe the level of need/demand for each proposed service as experienced by your organization, and the specific client group(s), by gender and ethnicity, in need for these services; specify the proposed program(s) target geographic area/populations.

4. Describe the service expansion(s) or modification(s) that you are proposing to provide in order to meet an identified need for the service(s). Proposed programs will only be funded when gaps in service or available funding are clearly identified, adequately documented, and a strong justification is made for using Ryan White Title I as opposed to other funding sources (i.e., target population which is not eligible for Medicaid or is not covered by private insurance). Include a description of how the Title I client case load will be maintained to ensure that all the dollars awarded will be spent by the end of the contract period, February 28, 2005.

   For-profit organizations must address each of the six points/requirements outlined in the "Formal Clarification of Legislative Language" issued by HRSA, dated March 6, 1997 **(See Attachment 1).**

5. Provide a description of your proposed service approach and the rationale underlying the approach to be taken in providing the service; include an explanation of how your organization is planning to integrate Title I services with other services, including services your agency provides and those available elsewhere in the community. In addition, provide a description of how your organization will provide culturally sensitive services to specific

racial/ethnic groups, and how it will monitor client's adherence to treatment and how adherence problems will be identified and resolved.

6. Describe your organization's specific policies regarding quality of care in the provision of the proposed service, and describe all processes established to ensure quality of services to HIV/AIDS clients.

7. Describe your organization's intake process; explain how your agency will deal with "Walk-ins," especially those in crisis; include an explanation of how your organization monitors the availability of slots for specific services.

8. Provide a schedule of hours of operation for each proposed service, a list of sites where each service will be available, and estimates of the number of clients to be served and the number of units of service to be provided. **Organizations proposing to provide Minority AIDS Initiative (MAI) services must document that the proposed service sites are located or near the community(ies) of color targeted in their proposal.**

9. If your organization is proposing to provide case management services, explain how your case management activities will be integrated with the Title I case management system to ensure comprehensive, continuous, and integrated care. Describe any case management system currently in place at your organization. Describe how the organization utilizes its case management system to perform proper client eligibility screening for various sources of funding. Indicate your organization's current client load for case management services and the ratio of clients per case manager; specify the percentage of clients that are actively enrolled in your case management program.

10. If your organization is proposing to provide case management services, indicate which Ryan White Title I Coordinated Case Management Standards of Service **(Attachment 26)** your agency is in full compliance with at the time of proposal submission. In addition, identify your agency's proposed timeline for progress towards meeting those standards that it is not currently able to meet.

11. If your organization is proposing to provide outpatient medical care (primary care services), indicate which medical care standards **(Attachment 27)** your agency is in full compliance with at the time of proposal submission. In addition, describe your agency's efforts to provide the level of primary care outlined in the standards and the proposed timeline to achieve full compliance.

12. If your organization is proposing to provide prescription drugs services, describe how it will maintain and track a separate inventory of drugs purchased with Title I funds (drug inventory must be physically separated from drugs purchased with non-Title I dollars). In addition, describe your organization's policies and procedures for purchasing, receiving, storing, and distributing prescription drugs. Furthermore, discuss your organization's policies and procedures for maintaining and disposing prescription drugs records.

13. Indicate if staff required to provide the service(s) is currently on board or if recruitment will be necessary. Identify a staff person to serve as the Contract Coordinator or liaison; said individual will monitor the contract provisions and must be available to meet with the County's staff to review activities on an "as needed" basis.

NOTE: After proposal submission, but prior to the award of any contract issued as a result of this RFP, the Proposer has a continuing obligation to advise the County of any changes, intended or otherwise, to the key personnel identified in its proposal for each service category.

14. Describe and enclose as **Appendix 6** any licensure requirements and or accreditations that have been met by your organization and/or key members of your proposed project staff.

15. Enclose as **Appendix 7** resumes, job descriptions, and copies of required licenses for the person who will be the principal liaison to the County and key professional staff who will be providing direct services to clients. **(Approximately one page per person).** For local preference points consideration, resumes for all personnel **MUST** indicate each individual's city, county and state of permanent residence; and, in addition, the resumes MUST indicate the city, county and state where the individual's permanent office, within the proposing organization, is located.

16. Proposers are required to submit a detailed work plan for the proposed service(s). The work plan should describe the goals, objectives, activities, staff person(s) responsible for achieving the objectives, target activity/task start date, dates when compliance with Ryan White Title I standards will be met, or target activity/task completion date. Objectives must be specific and quantifiable, including the units of service to be provided and the number of clients to be served. Additional instructions for completing the work plan are provided on the reverse side of the form **(Attachment 32).**

G. Line Item Budget and Price Forms

1. Due to Federal requirements, the Proposer(s) **MUST** submit a categorical line item budget **(Attachment 15)** and narrative justification **(Attachment 16)** for each direct and indirect cost associated with the proposed service, using the object class categories listed below. A total dollar amount for indirect charges without a detailed breakdown on the budget form will not be accepted. Failure to submit the categorical budget with your proposal will **DISQUALIFY** your organization for further consideration by the Evaluation/Selection Committee for award of funds.

   Object Class Categories - Personnel (salaries and fringe benefits), contractual expenses, supplies, travel, equipment, other direct costs, and indirect administrative charges. The line item budget should include all program related expenses for which funds are being requested. A narrative justification must be included as part of this section, specifying how each line item is directly related and/or necessary to the provision of direct patient care and services. The justification must also include a detailed description of how unit costs and/or dispensing charges were calculated. **Attachment 1** provides a set of guidelines for the preparation of a budget justification as well as examples of allowable direct and indirect costs for each Title I service category. **Indirect/Administrative costs are capped at 10%.** Proposers are required to follow the budget limitations and reimbursement caps established by the Miami-Dade HIV/AIDS Partnership as identified in this RFP under **Section 2.0, Scope of Services**.

2. Complete the Price Form(s) for the proposed service(s). Instructions for completing the Price Forms are provided on the reverse side of each form **(Attachments 20-21a and 22-24b).** Proposer(s) **MUST** provide all of the required information on the forms and **MUST** include the signature of an official who is authorized to enter into a contractual agreement on behalf of the organization. The proposer(s) **MUST** affix their corporate seal to this

document. In the absence of a corporate seal this document may be notarized by a notary public. The original copy of the Price Form **MUST** be clearly marked as such.

Proposers are reminded that if the department designated by the County Manager to administer the grant determines, based on average monthly reimbursements, that the service providers are not spending at a rate that indicates they will expend their full allocation(s) within the contract period, the dollar amount awarded to the service provider(s) for these categories of service will be reduced accordingly. The County has, in the past, reduced allocations of service providers whose monthly projections indicated they would not expend their allocations. The County will continue with this practice in the future to insure that the level of Ryan White Title I funding received by Miami-Dade County is not reduced in the coming years due to the inability to expend previously allocated grant funds.

H. Required Affidavits/Acknowledgments

Proposers MUST complete, sign as required, and submit the following documents as part of this RFP:

1. All Proposers **MUST** acknowledge receipt of all the addenda issued in relation to this RFP. Acknowledgment of Addenda must be included with your proposal **(Attachment 3)** as **Section H.1** of the proposal. Proposers should telephone the contact person for this RFP prior to submission of their proposal to verify that they have received all addenda issued.

2. All Proposers are advised that in accordance with Section 2-11.1 (s) of the Code of Miami-Dade County, the Lobbyists Registration for Oral Presentation Affidavit **MUST** be completed, notarized and included with your proposal submission. Lobbyist specifically includes the principal, as well as any agent, officer or employee of a principal, regardless of whether such lobbying activities fall within the normal scope of employment of such agent, officer or employee **(Attachment 4)** as **Section H.2** of the proposal.

3. All Proposers **MUST** complete and include the Miami-Dade County Affidavit – Taxes, Fees, and Parking Tickets Have Been Paid **(Attachment 11)** as **Section H.3** of the proposal. This Affidavit, which attests that all delinquent and currently due fees, taxes, and parking tickets owed to the Miami-Dade County by the Proposer(s) have been paid, **MUST** be signed by an authorized agent of the proposing organization and notarized.

4. All Proposers **MUST** complete and include the Disability Nondiscrimination Affidavit **(Attachment 14)** as **Section H.4** of the proposal. This Affidavit, which attests that the organization is in compliance with ADA standards, should be signed by an authorized agent and notarized.

5. Proposers **MUST** complete and include, if applicable, as **Section H.5** of the proposal, the Local Business Preference Form **(Attachment 6).** This form must be appropriately completed, signed by an authorized agent and notarized and submitted as part of the Proposer(s) response to this solicitation in order to be considered for Local Preference points.

6. All Proposers **MUST** complete and include as **Section H.6.a** of the proposal, the Proposer's Disclosure of Subcontractors and Suppliers Form **(Attachment 7).** This form must be submitted to identify all first tier subcontractors or subconsultants which will perform any part of the contract work and all suppliers which will directly supply materials to the selected Proposer for the contract work. In addition, Proposers **MUST** complete and include, as **Section H.6.b** of the proposal, the Proposer's Disclosure of Fair Subcontracting Policies **(Attachment 8).** This form must be submitted to provide a statement of the Proposer's subcontracting policies and procedures. Both forms must be signed by an authorized agent of the proposing organization. **IMPORTANT: Failure to complete these forms in their entirety or indicating "Not Applicable (N/A)" on sections of the forms will deem the proposal non-responsive.**

7. Proposing organizations with **annual gross revenues in excess of $5 million MUST** submit as **Section H.7.a** of their proposal a written Affirmative Action Plan and Procurement Policy Affidavit **(Attachment 9)** which must remain on file with the Miami-Dade County's Department of Business Development. Proposing organizations whose Board of Directors is representative of the population make-up of the nation are exempt from this requirement and may claim exemption by submitting as **Section H.7.b** of their proposal the Affirmative Action Plan Exemption Affidavit **(Attachment 10).**

8. All Proposers **MUST** complete and include the Code of Business Ethics Affidavit **(Attachment 12)** as **Section H.8** of the proposal. This Affidavit, which attests that the organization is fully compliant with the requirements of Section 2-8.1(1) of the Code of Miami-Dade county as amended, and has adopted the County's Code of Business Ethics, should be signed by an

authorized agent and notarized. Please also see Section 1.36 of this RFP for more details.

9. Proposers **MUST** complete, if applicable, and submit prior to entering into a contract with or receiving funding from Miami-Dade County the Criminal Record Affidavit. This form, which is available from the Department of Procurement Management/Office of Vendor Assistance at (305) 375-5287, must be submitted if the Proposer has been convicted of a felony during the past ten years.

10. Proposers **MUST** complete , if applicable, and submit prior to entering into a contract with or receiving funding from Miami-Dade County the Domestic Violence Leave Affidavit **(Attachment 13).** This form must be submitted if the Proposer has, in the regular course of business, fifty (50) or more employees working in Miami-Dade County for each working day during each of the twenty (20) or more calendar work weeks in the current or preceding calendar year.

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3.3 QUALIFICATIONS/STATEMENT OF QUALIFICATIONS

Due to the reauthorization in 1996 of the Ryan White Comprehensive AIDS Resource Emergency (CARE) Act, Title I funds **may not** be awarded to private for-profit entities, unless such entities are the "only available provider of quality HIV care in the area." [SEC 2604 (b)(2)(A); SEC 2613 (a)(1)]. Please refer to **Attachment 1** for more details regarding this legislation. Private not-for-profit service providers must be able to show proof of such status by submitting, as part of the proposal, appropriate documentation in the name of the proposing organization and any subcontractors, if applicable, stating not-for-profit status.

The successful Proposers **MUST** have sufficient financial resources to meet the expenses incurred during the period between the purchase of services and payment by the County. It is anticipated that the County will pay for services rendered within four to six weeks of the receipt of invoices, deemed correct and acceptable by the County.

Additional specific qualifications which are applicable to a particular service are included in Section 2.0, Scope of Services.

3.4 PROPOSAL SUBMISSION REQUIREMENTS

All material is to be submitted on 8 1/2" x 11" paper, neatly typed on one side only with standard margins, line and character spacing (12 characters per inch). One unbound original and fifteen (15) unbound copies (a total of 16) are required (see Section 3.0). Enclosures are required to be listed in the Table of Contents. The original Proposal Title Page **(Attachment 1)** and the original Price Forms **(Attachments 20 – 21a and 22 –24b)** must have an authorized signature and must be notarized. The original copy of the proposal **MUST** be clearly marked as such on the Proposal Title Page, containing original signatures, original corporate seal and/or Notary Public stamp. Additional copies of the proposal do not need to bear original signatures nor original stamps. Proposers shall include their complete return address on the outer envelope wrapper enclosing any materials submitted in response to this RFP. The outer envelope or wrapper for the **original and copies** of the proposal should be addressed as follows (see next page):

Proposer's Name
Proposer's Address
Proposer's Telephone Number

Miami-Dade County
Clerk of the Board of County Commissioners
Stephen P. Clark Center
111 N.W. 1st Street, 17th Floor, Suite 202
Miami, Florida 33128

RFP No. RW1401
Health and Support Services for Persons with HIV Spectrum Disease
Ryan White Title I Program
Proposal Due Date – 05/14/04

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SECTION 4.0 EVALUATION/SELECTION PROCESS

The evaluation of proposals and selection of award recommendations will be made during the evaluation/selection process. Proposals will be evaluated by an Evaluation/Selection Committee appointed by the County Manager comprised of appropriate County personnel from multiple departments and representatives of the community, as deemed necessary, with the appropriate experience and/or knowledge striving to ensure that the committee is balanced with regard to both ethnicity and gender.

The method of contract award will be based on a qualitative appraisal rating and ranking of responsive Proposers based on point totals for each evaluation criteria and not on a percentage factor. The Evaluation/Selection Committee will evaluate and rank responsive proposals on the evaluation criteria listed below. The criteria are itemized with their respective weights for a **maximum of 100 points**. A proposer may receive the maximum points or a portion of this score depending on the merit of its proposal, as determined by the Evaluation/Selection Committee.

After the qualitative appraisal, rating and ranking evaluation, the committee may choose to conduct oral presentations from those Proposers ranked the highest. Upon completion of the oral presentation(s), if conducted, the Committee will re-evaluate, re-rate and re-rank the proposals remaining in consideration based upon the written documents combined with the oral presentation.

Following the qualitative appraisal and oral presentations (if conducted), the Evaluation/Selection Committee will then report its findings as to relative merit and recommendation for contract award to the County Manager for his review and concurrence.

The County Manager will present his recommendation to the Board of County Commissioners, who, as the duly elected representatives of the residents of Miami-Dade County, have the sole authority to award contracts on behalf of the County.

4.1 EVALUATION CRITERIA

A. Organizational Longevity, Experience, Minority Representation on the Board of Directors or Among Professional/Volunteer Staff (15 points):

- Period of time that the proposing organization has been providing services **[Up to 2 points];**

- Period of time that key supervisory and direct service staff have been providing services to people with HIV/AIDS **[Up to 8 points];**

- Representation of minority racial/ethnic groups in the organization's Board of Directors or among its professional/volunteer staff **[Up to 5 points].**

B. Administration and Cost (30 points):

- Line-item budget is complete, well documented, and yields reasonable unit-cost calculations **[Up to 5 points];**

- Proposing organization's unit costs, relative to those proposed by other programs providing similar services **[10 points]; NOTE:** Proposers will be given points proportionately in relation to the lowest unit cost. This point total will be calculated by dividing the lowest unit cost by the unit cost of the proposal being evaluated with the result being multiplied by the maximum weight for this criteria (10 points) to arrive at a cost score.

Example:	Lowest Unit Cost Proposed / Proposed Unit Cost	X	Total Points = for Cost	Cost Score

The application of the above formula will result in a uniform assignment of points relative to the criterion of cost [Up to 10 points].

The pricing formula is used as part of the evaluation process to determine the highest ranked proposer. The County reserves the right to negotiate the final terms, conditions and pricing of the contract as may be in the best interest of the County.

- Proposing organization's financial capability to undertake the proposed scope of work on a reimbursement basis **[Up to 5 points];**

- Proposing organization's plan for using Ryan White Title I dollars as the funding source of last resort (is the plan workable or not?); the organization has demonstrated the ability to use sliding fee scales, co-payments, alternative public funding streams, and/or private insurance **[Up to 5 points];**

- Proposing organization's ability to meet Ryan White Title I fiscal and administrative reporting requirements **[Up to 5 points].**

C. Quality of Service Delivery (20 points):

- Proposing organization's ability to identify and address a significant gap in existing funded services for people with HIV/AIDS, including service gaps among particular racial/ethnic groups **[Up to 5 points];**

- Proposed services are well planned and detailed and address the requirements included in Section 2.0, Scope of Services **[Up to 5 points];**

- Proposing organization's documentation of working referral relations and linkage agreements with Ryan White Title I and non-Ryan White Title I providers **[Up to 5 points];**

- Proposing organization's mechanism for reviewing the quality of client care, to detect exceptions, and to ensure remedy of service delivery problems; proposing organization's policy regarding compassionate, courteous, culturally sensitive and non-judgmental service toward their clients with HIV/AIDS; proposing organization's plan for the integration of services funded under Ryan White Title I with other non-Ryan White services offered within the agency **[Up to 5 points].**

D. Barriers to Utilization (30 points):

- Provision of services with regards to high need areas, traditionally underserved areas, or high need populations (i.e., specific racial/ethnic groups) **[Up to 10 points];**

- Proposing organization's ability to ensure that persons with HIV/AIDS play a role in delivering services or making decisions within the organization **[Up to 5 points];**

- Proposing organization's provisions for clients who are disabled or who have problems with transportation **[Up to 5 points];**

- Proposing organization's cultural sensitivity as demonstrated by its willingness and ability to accommodate clients of different languages, racial and ethnic groups, and other special populations **[Up to 5 points];** and

- Proposing organization's grievance process **[Up to 5 points].**

E. Compliance with RFP (5 points):

- Proposal's inclusion of all required elements without significant omissions or inconsistencies, following the required format, and its conciseness **[Up to 5 points].**

4.2 LOCAL PREFERENCE

Local Preference may be taken into consideration in accordance with Section 1.22,"Local Preference." If following the completion of final rankings by the Evaluation/Selection Committee, a non-local Proposer is the highest ranked responsive and responsible Proposer, and the ranking of a responsive and responsible local Proposer is within 5% of the ranking obtained by the non-local Proposer, then the highest ranked local Proposer shall have the opportunity to proceed to negotiations with the County.

4.3 CONTRACT AWARD

All Proposers will be notified in writing when the County Manager or designee makes an award recommendation. The Contract award(s), if any, shall be made to the Proposer(s) whose proposal(s) shall be deemed by the Board of County Commissioners to be in the best interest of the County. The Board of County Commissioners' decision of whether to make the award(s) and which proposal(s) are in the best interest of the County shall be final.

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SECTION 5.0 GENERAL PROVISIONS

5.1 CONTRACT TERM AND RENEWAL

The initial term of the contract to be awarded shall be for a period of approximately five to six (6) months, commencing on September 20, 2004 (or earlier) and continuing through February 28, 2005. The contract shall automatically renew on a year-to-year basis at the end of each term for a one year term, not to exceed five years from the end of the initial contract term, with the approval of both parties, and upon execution of a renewal agreement containing the same terms and conditions except for necessary adjustments to the maximum amounts payable.

5.2 NUMBER OF GRANTS TO BE AWARDED

It is anticipated that the County will enter into more than one agreement as a result of this RFP.

5.3 RIGHT TO INSPECT

The successful Proposer(s)' books and records, as they relate to the contracts to be awarded, **MUST** be made available for inspection and/or audit by the County, HRSA, and any organization conducting reviews on behalf of the Miami-Dade HIV/AIDS Partnership without notice. In addition, all records pertaining to the contracts **MUST** be retained in proper order by the successful Proposers for **at least five (5)** years following the expiration of the agreements.

5.4 ASSIGNMENT

The successful Proposer(s) shall not enter into any subcontracts, retain consultants, or assign, transfer, convey, sublet, or otherwise dispose of the ensuing contracts, or any or all of its rights, title or interest herein, or its power to execute such contracts to any person, company or corporation without the prior written consent of the County.

5.5 CANCELLATION

Either the successful Proposer(s) or the County may cancel the ensuing contracts without stated cause at any time by giving **ninety (90) days prior written notice** via registered mail/return receipt requested.

5.6 TERMINATION

If the successful Proposer(s) shall fail to fulfill, in a timely manner, the obligations under the Ryan White Title I Agreement, or shall violate any of the covenants, agreements, stipulations, representations or warranties hereof, the County shall have the right to terminate the Agreement or reduce service by giving at least five (5) days prior written notice to the successful Proposer(s) of such intent to terminate or reduce service.

5.7 PERSONNEL

In submitting their proposals, Proposers are representing that the personnel described in their proposals shall be available to perform the service described, barring illness, accident, or other unforeseeable events of a similar nature in which cases the successful Proposer(s) **MUST** be able to provide a qualified replacement. All replacements **MUST** be approved by the County prior to providing services. Furthermore, all personnel shall be considered to be, at all times, the sole employees of the service provider under its sole direction, and not employees or agents of the County.

5.8 INDEMNIFICATION

The successful Proposer(s) shall indemnify and hold harmless the County and its officers, employees, agents and instrumentalities from any and all liability, losses or damages, including attorney's fees and costs of defense, which the County or its officers, employees, agents or instrumentalities may incur as a result of claims, demands, suits, causes of actions or proceedings of any kind or nature arising out of, relating to or resulting from the performance of this Agreement by the Proposer(s) or its employees, agents, servants, partners principals or subcontractors. The successful Proposer(s) shall pay all claims and losses in connection therewith and shall investigate and defend all claims, suits or actions of any kind or nature in the name of the County, where applicable, including appellate proceedings, and shall pay all costs, judgments, and attorney's fees which may issue thereon. The successful Proposer(s) expressly understands and agrees that any insurance protection required by this Agreement or otherwise provided by the Proposer(s) shall in no way limit the responsibility to indemnify, keep and save harmless and defend the County or its officers, employees, agents and instrumentalities as herein provided.

5.9 INSURANCE

The successful Proposer(s) shall furnish to Miami-Dade County General Services Administration, c/o Risk Management Division, 111 N.W. 1st Street, Suite 2340, Miami, Florida 33128-1989, Certificate(s) of Insurance which indicate that insurance coverage has been obtained which meets the requirements as outlined below:

A. Worker's Compensation Insurance for all employees of the provider as required by Florida Statute 440.

B. Public Liability Insurance on a comprehensive basis in an amount not less than $300,000 combined single limit per occurrence for bodily injury and property damage. Miami-Dade County must be shown as an additional insured with respect to this coverage.

C. Automobile Liability Insurance covering all owned, non-owned and hired vehicles used in connection with the work, in an amount not less than $300,000* combined single limit per occurrence for bodily injury and property damage.

* Note: For providers supplying vans or mini-busses with seating capacities of 15 passengers or more, the limit of liability required for Auto Liability is $500,000.

D. Professional Liability Insurance in the name of the provider in an amount not less than $250,000 with the deductible per claim, if any, not to exceed 10% of the limit of the liability.

E. All insurance policies required above shall be issued by companies authorized to do business under the laws of the State of Florida, with the following qualifications:

1) The company must be rated no less than "B" as to management, and no less than "Class V" as to financial strength, by the latest edition of Best's Insurance Guide, published by A.M. Best Company, Oldwick, New Jersey, or its equivalent subject to the approval of Miami-Dade County's Risk Management Division.

or,

2) The company must hold a valid Florida Certificate of Authority as shown in the latest "List of All Insurance Companies Authorized or Approved to Do Business in Florida", issued by the State of Florida Department of Insurance and must be a member of the Florida Guaranty Fund.

G. Certificates **MUST** indicate that no modification or change in insurance shall be made without thirty (30) days written advance notice to the certificate holder.

H. Compliance with the foregoing requirements **shall not** relieve the provider of its liability and obligations under this section or under any other section of the Agreement.

The provider **MUST** notify the County of any intended changes in insurance coverage, including any renewals of existing policies.

5.10 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

To successful Proposer (s) shall comply with the requirements set forth in Section 381.004 of the Florida Statutes which governs the confidentiality of medical records related to a patients/clients HIV status. Notwithstanding these obligations, where State laws do not prevail, the Proposer further agrees to comply with the requirements set forth in HIPPA. Any person or entity that performs or assists Miami-Dade County with a function or activity involving the use or disclosure of "Individually Identifiable Health Information (IIHI) and/or Protected Health Information (PHI) shall comply with the HIPAA and the Miami-Dade County Privacy Standards Administrative Order. HIPAA mandates for privacy, security and electronic transfer standards that include but are not limited to:

(1) Use of information only for performing services required under this Agreement or as required by law;
(2) Use of appropriate safeguards to prevent non-permitted disclosures;
(3) Reporting to Miami-Dade County of any non-permitted use or disclosure;
(4) Assurances that any agents and subcontractors agree to the same restrictions and conditions that apply to the Proposer and reasonable assurances that IIHI/PHI will be held confidential;
(5) Making PHI available to the client;
(6) Making PHI available to the client for review and amendment; and incorporating any amendments requested by the client;
(7) Making PHI available to Miami-Dade County for an accounting of disclosures; and
(8) Making internal practices, books and records related to PHI available to Miami-Dade County for compliance audits.

PHI shall maintain its protected status regardless of the form and method of transmission (paper records, and/or electronic transfer of data). The proposing organization must give its clients written notice of its privacy information practices, including specifically, a description of the types of uses and disclosures that would be made with Protected Health Information and must post and distribute to Title I service recipients the COUNTY's Notice of Privacy Practices **(Attachment 35)**.

5.11 NEPOTISM

No relative of any officer, board of director, manager, or supervisor shall be employed by the Proposer unless the employment preceded the execution of the Ryan White Title I Agreement by one year. A conflict of interest in employment arises whenever an individual would otherwise have the responsibility to make, or participate actively in making decisions or recommendations relating to the employment status of another individual if the two individuals (herein sometimes called "related individuals") have one of the following relationships:

(1) by blood or adoption: Parent, child, sibling, first cousin, uncle, aunt, nephew, or niece;
(2) by marriage: Current or former spouse, brother- or sister-in-law, father- or mother-in-law, son- or daughter-in-law, step-parent, or step-child; or
(3) other relationship: A current or former relationship, occurring outside the work setting, that would make it difficult for the individual with the responsibility to make a decision or recommendation to be objective, or that would create the appearance that such individual could not be objective. Examples include, but are not limited to, personal relationships and significant business relationships.

For purposes of this section, decisions or recommendations related to employment status include decisions related to hiring, salary, working conditions, working responsibilities, evaluation, promotion, and termination.

An individual, however, is not deemed to make or actively participate in making decisions or recommendations if that individual's participation is limited to routine approvals and the individual plays no role involving the exercise of any discretion in the decision-making processes. If any question arises whether an individual's participation is greater than is permitted by this paragraph, the matter shall be immediately referred to the Miami-Dade County Commission on Ethics and Public Trust.

This section applies to both full-time and part-time employees and voting members of the Proposer's Board of Directors.

SECTION 6.0 SPECIAL TERMS AND CONDITIONS

6.1 LEVEL OF EFFORT AND FUNDING

It should be clearly understood, that the services requested in this RFP are on an "as needed basis" and that the dollar values referred to in this RFP in no way constitute a guarantee of the level of effort that may be requested of the successful Proposer(s) or a guaranteed payment of the maximum amount payable.

6.2 CONTRACTING PROCESS

The successful Proposer(s) will be required to submit all documents necessary for contract development (i.e., revised budget and justification, revised price form, scope of service, vendor application, insurance certificates, affidavits, work plan, etc.) within two weeks from receipt of written notice of contract award from the County.

6.3 PROGRAM IMPLEMENTATION AND WORK PLAN

Proposer(s) are required to submit a detailed work plan for each funded service/program that reflects a service start target date of no more than fifteen (15) days after receipt of written notice of contract award. Providers are required to inform the County, in writing, of any proposed deviation from the approved work plan. The successful Proposer(s) will also be required to obtain written approval from the County for any revisions to the approved work plan **(Attachment).**

6.4. FUNDING RESTRICTIONS

1. Proposers agree that funds received under the agreement shall be utilized to supplement, not supplant, state and local HIV/AIDS related funding or in-kind resources made available in the year for which this agreement is awarded to provide HIV/AIDS related services to persons living with HIV/AIDS. In addition, Proposers must agree to make all necessary efforts to ensure that clients are appropriately screened for eligibility under all other pertinent benefits programs.

2. Funds shall not be used to:

    a. Make payments for any item or service to the extent that payment has been made or can reasonably be expected to be made by a third party payor, with respect to that item or service:

1) Under any state compensation program, insurance policy, or any Federal or State health benefits program; or

2) By an entity that provides health services on a prepaid basis.

b. Purchase or improve land, or to purchase, construct or make permanent improvement to any building.

c. Make direct payments to recipients of services.

3. Proposers agree that all equipment and products purchased with grant funds should be American-made.

6.5 REIMBURSEMENT

The service provider **MUST** invoice Miami-Dade County for the service for which a contract has been awarded, on a monthly basis, on or before the twentieth day of each month following the month in which the service was rendered, unless the COUNTY has granted the service provider an extension in writing. Reimbursement shall be on the basis of unit cost or line item budget, where applicable. It is anticipated that the County will reimburse providers within four (4) to six (6) weeks from receipt of complete and error free invoices.

Failure to submit monthly reimbursement requests in a manner deemed correct and acceptable by the County, by the twentieth day of each month following the month in which the service was delivered, shall deem the service provider in non-compliance with this covenant (unless an extension was granted) and, at the option of the County, the provider will forfeit its claim to any reimbursements for that specific month's reimbursement request, or the County may invoke the termination provision in the ensuing contract by giving five (5) days written notice of such action to be taken.

Any payment due to the provider may be withheld pending receipt and approval by the County of all reports and documents due from the service provider.

6.6 AWARD / BUDGET REDUCTION

If the department designated by the County Manager to administer the grant determines, based on average monthly reimbursements, that a service provider is not spending at a rate that indicates it will expend its full allocation within the contract period, the dollar amount awarded to the service provider will be reduced accordingly. The County will notify the provider, in writing, of any reductions made to existing budgets. Monthly expenditure reports will be distributed to the Miami-Dade HIV/AIDS Partnership and the Board of

County Commissioners throughout the contract period. These reports will reflect actual reimbursement figures only.

6.7 CERTIFICATE OF STATUS

The successful Proposer **MUST** submit to Miami-Dade County, within thirty (30) days of contract execution, a Certificate of Status in the name of the service provider, which certifies the following: that the provider is organized under the laws of the State of Florida, the filing date, that all fees and penalties have been paid, that the service provider's most recent annual report has been filed, that its status is active, and that the provider has not filed Articles of Dissolution.

6.8 AUDIT

The successful Proposer **MUST** provide Miami-Dade County a complete copy of its annual, agency wide, audit reports performed by independent auditors covering each of the successful Proposer's fiscal years for which Ryan White Title I funds are awarded. Audits of government entities must comply with OMB Circular A-128, audits of non-profit organizations, non-government entities, hospitals, and institutions of higher education must comply with OMB Circular A-133, audits of for-profit organizations must comply with OMB Circular A-133 in combination with 48CFR, Subpart 31.

6.9 ELIGIBILITY DOCUMENTATION

Clients **MUST** be documented as being permanent residents of Miami-Dade County, as being HIV+ or as having AIDS and as being financially eligible. Copies of this documentation are to be kept on-site, in the client's file, by the provider.

Acceptable Proof of Medical Eligibility: Lab test result, a note on physician's letterhead that is specific to the client's HIV status and is signed by a doctor, a diagnosis by a physician as reflected in the client's medical records, a positive HIV viral culture or test result, a detectable HIV viral load or viral resistance test, or a Ryan White Title I Certified Referral Form from a Title I funded service provider indicating the type of documentation that is maintained on file at the referring agency, and signature of the individual making the referral.

Acceptable Proof of Financial Eligibility: Client's pay stub, pay stub of a supplemental income check, copy of a complete W-2 form, copy of an income tax return, a letter from Medicaid office indicating the client's employment disability status, a copy of the client's Medicaid card if income level is indicated, a copy of completed Department of Health public assistance eligibility forms, a copy of SSI card if income level is indicated, a letter from the Social Security Income Office indicating the client's income level, or a certified referral form

from a Title I funded provider which must include the name of the referring agency, type of proof of income status kept on file by the referring agency, and signature of the individual making the referral. In isolated instances when the client is not able to provide any of the above-mentioned documents, a letter from the head of the household indicating income, a letter from the client's employer, or a signed disclosure from the client will be accepted.

Acceptable Proof of Permanent Residency (in Miami-Dade County): a copy of the client's State of Florida driver's license; State of Florida Identification Card; rental lease, mortgage or rent receipts in the name of the client indicating a physical living address in Miami-Dade County; Declaration of Residence as issued by the Miami-Dade County Courthouse; Miami-Dade County utility bills in the client's name; or a Ryan White Title I Certified Referral Form from a Title I funded service provider indicating the type of documentation that is maintained on file at the referral site, will be accepted.

6.10 RECEIPT FOR SERVICE

The service provider **MUST** issue each client a receipt for services provided and **MUST** request the client's signature. This receipt **MUST** include the definition of the unit of service or procedure rendered, the unit/procedure cost, the number of units provided, and total charges for the service. A copy of the receipt, signed by the client, **MUST** be kept in the client's file.

6.11 RECORDS TRANSFER

The service provider **MUST** make available client records, as permissible by law, within **ten (10) working days** from the receipt of a written request or consent from the client.

6.12 REPORTS

The service provider **MUST** submit any and all reports to the County for the service, for which a contract has been awarded, by the date(s) and time(s) to be specified at a later date. These reports will include, but are not limited to the following:

A. Work plan(s) and deviation notices **(Attachment 32);**

B. Monthly reimbursement requests - service utilization reports **(Attachment 29);**

C. Client level intake information **(Attachment 30);**

D. Ryan White C.A.R.E. Act Data Report - agency level information **(Attachment 31);** and

E. Special requests for additional information, as necessary, to comply with Federal and County requirements.

All reports are subject to on-site verification and audit of provider records. Failure to submit any and all reports in a manner deemed acceptable by the County, by the date(s) and time(s) to be specified, shall deem the Provider in non-compliance with this covenant and the County will invoke the termination provision in the ensuing contract by giving five (5) days written notice of such action to be taken.

6.13 PROGRAM EVALUATION

Proposers also agree to participate in evaluation studies sponsored by the U.S. Health Resources and Services Administration (HRSA) and/or analysis carried out by or on behalf of the Miami-Dade HIV/AIDS Partnership to evaluate the effect of client service activities, or on the appropriateness and quality of services. This participation shall, at a minimum, include permitting right of access of staff involved in such efforts to the Proposer's premises and records. Furthermore, the Proposer(s) agree to participate in ongoing meetings or task forces aimed to increase, enhance and maintain coordination and collaboration among HIV/AIDS related health and support service providers.

6.14 SERVICE PROVIDER'S INTERNAL GRIEVANCE PROCEDURE

The service provider **MUST** establish internal grievance procedures and cooperate with the Miami-Dade HIV/AIDS Partnership and the County, in addressing all complaints and/or problems identified by clients and/or other care providers. The provider's internal grievance procedure **MUST** include, at a minimum, the following: provider's written response to the client; and a client meeting with organization's Executive Director, board member, or their designee.

6.15 MIAMI-DADE HIV/AIDS PARTNERSHIP NOTICES

The service provider is required to post notices, in a timely manner, provided by the County regarding Miami-Dade HIV/AIDS Partnership and Miami-Dade County activities.

6.16 LICENSES

All licensed professionals, including those of any subcontractor, are required to have appropriate training and experience in the field in which they practice and to abide by all applicable State and Federal laws and regulations and ethical standards consistent with those established for their profession and to possess all required State of Florida licenses, as well as

Miami-Dade County Occupational license(s). The provider is required to notify the County of any changes in licensure, including but not limited to the failure to maintain the required State of Florida licenses as a result of termination, suspension or revocation, within twenty (20) days from the date said incident occurs.

6.17 ASSIGNMENT

The provider must agree to assign any proceeds to the County from any contract, including this agreement, between the County, its agencies or instrumentalities and the provider or any firm, corporation, partnership or joint venture in which the provider has a controlling financial interest in order to secure repayment of any loan made to the provider under this or any other agreement for which the County discovers through its inspection, review and/or audit was not reimbursable. "Controlling interest" shall mean ownership, directly or indirectly to ten percent or more of the outstanding capital stock in any corporation or a direct or indirect interest of ten percent or more in a firm, partnership or other business entity.

6.18 RECAPTURE OF FUNDS

The County retains the right to recapture any funds disbursed to the provider to which the provider was not entitled. Upon written notice to the provider, the County shall have the right to withhold any payments under this agreement or seek reimbursement directly from the provider. Upon withholding or seeking reimbursement from the provider, the County has the right to retain said funds.

6.19 DAMAGES

The provider shall be liable to the County for damages sustained by the County by virtue of any breach of the contract or any other agreement by the provider, and the County may withhold any payments due to the provider until such time as the exact amount of damages due to the County from the provider is determined and properly settled.

SECTION 7.0
ATTACHMENTS

RFP No. RW1401
ATTACHMENT 1a

MIAMI-DADE COUNTY, FLORIDA

OFFICE OF STRATEGIC BUSINESS MANAGEMENT
RYAN WHITE TITLE I PROGRAM
140 WEST FLAGLER STREET
ROOM 1604
MIAMI, FLORIDA 33130-1563
(305) 375-4742
FAX (305) 375-4454

MIAMI-DADE

February 17, 2004

Dear Proposer:

RE: Federal Restrictions on Contracting with For-Profit Entities

This letter is to inform all Title I funded providers of formal clarification received from the Division of HIV Services (DHS) regarding legislation impacting Title I funding to private for-profit entities. Essentially, this legislation prohibits the use of Title I funding to private for-profit entities unless it is the only available provider for quality HIV services. Please refer to the attached "DSS Program Policy Guidance No. 4: Clarification of Legislative Language Regarding Contracting with For-Profit Entities" document from the Department of Human Services for specific limitations in the C.A.R.E. Act Amendments relating to this issue. (Please see *www.hab.hrsa.gov/i/dss_policies.htm* for more details.)

It is important to note that these conditions will apply to this RFP process for new FY 2004 contracts. It is important to note that this legislation is made at the Federal level and this office is required by law to enforce this legislation at the local level.

Please refer to the attached letter for additional specific information. If you have any questions related to this matter, please feel free to contact me at (305) 375-4742.

Sincerely,

Yocasta Juliao
Project Director

Attachment

Law & Policy: DSS Program Policy Guidance No. 4

Clarification of Legislative Language Regarding Contracting with For Profit Entities
Formerly a "Dear Colleague Letter" First Issued March 6, 1997 to
All Title I and II CARE Act Grantees
June 1, 2000

The CARE Act Amendments of 1996 provide for contracting with for-profit entities under certain limited circumstances. Specifically, the Amendments allow Title I and Title II funds to be used to "provide direct financial assistance" through contracts with "private for-profit entities if such entities are the only available provider of quality HIV care in the area." [SEC 2604(b))2)(A); SEC 2631(a)(1)]

This constitutes a formal clarification of legislative language by the Division of Service Systems, HIV/AIDS Bureau in consultation with the Grants Management Officer within the Bureau and with the Office of General Counsel of the Department of Health and Human Services, and is effective immediately.

Based on limitations contained in the CARE Act Amendments, grantees and other contracting agents must observe the following conditions in developing and implementing Requests for Proposals (RFP) and other local procurement procedures.

a. Only available provider means that there are no nonprofit organizations able and willing to provide quality HIV service and that the grantee or other contracting agent is able to document this fact.

b. Quality HIV care must be defined in a reasonable manner. Quality care **may not** be defined exclusively as a numerical score in an RFP process (i.e., all funds go to the highest scored proposal regardless of corporate status). An entity should only be deemed incapable of providing quality HIV care if written documentation of substantive quality of care deficiencies exists.

c. Cost of service **may not** be the sole determinant in vendor selection processes whether internal or external (i.e., all funds go to the lowest bidder regardless of corporate status). However, grantees should not overlook cost considerations in developing and implementing RFP processes and are in fact expected to seek maximum productivity for each CARE Act dollar within the contracting limits of the legislation.

d. Grantees must prohibit nonprofit contractors from serving as conduits who pass on their awards to for-profit corporations and **may** find it necessary to monitor membership of corporate boards in enforcing this prohibition. Federal Grants Management Policy is clear that the eligibility requirements that apply to first-level entities cannot be evaded by passing awards through to second- or subsequent-level entities that could not have received awards in the original competition.

e. Proof of nonprofit status (local and/or State registration and approved articles of incorporation) should be required of all applicants claiming such status. Grantees are also strongly advised to require copies of letters of determination from the Internal Revenue Service.

f. A grantee or other contracting agent **may not** contract with both nonprofit and for profit entities for the same service in the same geographic area unless qualified nonprofit providers do not have the capacity to meet identified need. Any nonprofit provider able to provide quality HIV care is given legislative preference over for-profit entities seeking to serve the same area.

No new contracts may be executed after the date of issuing this notice (3/7/97) that violate these conditions on contracts with private for-profit organizations. Any contracts in place using funds awarded in fiscal year 1997 or later are in violation of this program policy guidance notice. Failure to comply with this requirement may result in required return of funds to the Federal government, suspension of grant awards, or other remedies deemed necessary.

Grantees and other contracting agents are encouraged to include in all RFP materials disclaimers which advise private for-profit organizations of the significant legislative barriers to their receiving contracts. Alternatively, and if local/State regulations and laws allow it, grantees may seek to define "qualified applicants" at the beginning of the process in a way which would save private for-profit organizations the time and effort needed to develop applications which could not be considered for funding.

Any questions about this program policy should be directed to the grantee's Project Officer.

RFP No. RW1401
ATTACHMENT 2

RYAN WHITE TITLE I
PROPOSAL TITLE PAGE
HEALTH AND SUPPORT SERVICES FOR PERSONS WITH HIV SPECTRUM DISEASE
RFP NO.

Full, Legal Name of Organization	Local Address of Organization

Contact Person - (Liaison)	Contact Person - Address

Contact Person - Phone Number	Contact Person - Fax Number
Contact Person - E-Mail Address	**Federal Employer Identification Number**

Proposed Service(s)	Total $ Request	Proposed Service(s)	Total $ Request

I certify that all of the information contained in this proposal is true and accurate. I further understand that material omission or false information contained in this proposal constitutes grounds for disqualification of the Proposer(s) and this proposal.

Authorized Signature	Typed Name	Title	Date

Corporate Seal

OR

Sworn to and subscribed before me
this day of , 2004.

NOTARY PUBLIC, State of Florida
at Large

ACKNOWLEDGEMENT OF ADDENDA

Instructions: Complete Part I or Part II, whichever is applicable.

PART I: Listed below are the dates of issue for each Addendum received in connection with this solicitation.

Addendum #1, Dated _____, 200___

Addendum #2, Dated _____, 200___

Addendum #3, Dated _____, 200___

Addendum #4, Dated _____, 200___

Addendum #5, Dated _____, 200___

Addendum #6, Dated _____, 200___

Addendum #7, Dated _____, 200___

Addendum #8, Dated _____, 200___

Addendum #9, Dated _____, 200___

PART II:

____ No Addendum was received in connection with this solicitation.

Authorized Signature:_____ Date: _____

Print Name: _____ Title: _____

Federal Employer Identification Number: _____

Firm Name: _____

Address: _____

City/State/Zip: _____

Telephone: _____ Fax: _____

Miami-Dade County, Florida

RFP No. RW1401
ATTACHMENT 4

AFFIDAVIT OF MIAMI-DADE COUNTY LOBBYIST REGISTRATION FOR ORAL PRESENTATION

(1) Project Title:_____ Project No.:_____
(2) Department: _____
(3) Firm/Proposer's Name: _____
Address: _____ Zip: _____
Business Telephone: (_____) _____

(4) List All Members of the Presentation Team Who Will Be Participating in the Oral Presentation:

NAME	TITLE	EMPLOYED BY	TEL. NO.

(ATTACH ADDITIONAL SHEET IF NECESSARY)

The individuals named above are Registered and the Registration Fee is not required for the Oral Presentation ONLY. Proposers are advised that any individual substituted for or added to the presentation team after submittal of the proposal and filling by staff, MUST register with the Clerk of the Board and pay all applicable fees.

Other than for the oral presentation, Proposers who wish to address the county commission, a county board or county committee concerning any action, decision or recommendation of county personnel regarding this solicitation MUST register with the Clerk of the Board (Form BCCFORM2DOC) and pay all applicable fees.

I do solemnly swear that all the foregoing facts are true and correct and I have read or am familiar with the provisions of Section 2-11.1(s) of the Code of Metropolitan Dade County as amended.

Signature of Authorized Representative: _____
Title: _____
STATE OF _____
COUNTY OF _____

The foregoing instrument was acknowledged before me this _____,
by_____, a _____, who is personally known
(Individual, Officer, Partner or Agent) (Sole Proprietor, Corporation or Partnership)
to me or who has produced _____ as identification and who did/did not take an oath.

_____
Signature of person taking acknowledgement)

_____
(Name of Acknowledger typed, printed or stamped)

_____ _____
(Title or Rank) (Serial Number, if any)

RFP No. RW 1401
ATTACHMENT 5

MIAMI-DADE COUNTY
RYAN WHITE TITLE I GRANTEE

GRIEVANCE PROCEDURES AND PROCESS

REVISED 06/30/01

Miami-Dade County Ryan White Title I Grantee Grievance Procedures and Process

ARTICLE I

PREAMBLE

Miami-Dade County (hereinafter "County") adopts the following Grievance Procedures to provide, in accordance with the Ryan White Title I Health Care Services Program (42 USC § 300f-12 (a) (6) and 42 USC § 300f-12 (c) (A) and (B), an orderly procedure for resolving disputes concerning deviations from an established, written priority setting or resource allocation process (e.g., failure to follow established conflict of interests procedures), and deviations from an established, written process for any subsequent changes to priorities or allocations and those attendant rules and regulations that may effect such deviations form established processes, priorities, or allocations.

It is the policy of the County that an equitable solution of any grievance should be secured at the most immediate administrative level. These procedures should not be construed as limiting the right of any organization to discuss any concern with any member of the County. Nothing in this procedure shall be interpreted to limit the County's exclusive final authority over the management of the County's contracting and award process and selection of contractors and their awards.

ARTICLE II

DEFINITIONS

1. **Arbitration:** The submission of a dispute to an impartial or independent individual or panel for a binding determination. Arbitration is usually carried out in conformity with a set of rules. The decision of an arbitrator generally has the force of law, although it generally does not set a precedent.
2. **Arbitrator:** An individual or panel of individuals (usually three) selected to decide a dispute or grievance. Arbitrators may be selected by the parties or by an individual or entity.
3. **Binding:** A process in which parties agree to be bound by the decision of an arbitrator or other third party.
4. **Grievant:** Any person or entity whose grievance is presented to the County in accordance with this procedure.

Miami-Dade County Ryan White Title I Grantee Grievance Procedures and Process

5. **County:** Miami-Dade County.
6. **Costs:** Charges for administering a dispute settlement process.
7. **Day:** Refers to a calendar day or a business day, but excludes weekends and the County's recognized holidays. Either reference point can be used, as long as the grievant and the person or group against which the grievance is brought understand the applicable time frame.
8. **Dispute Prevention:** Techniques or approaches that are used by an organization to resolve disagreements at as early and informal a stage as possible to avoid or minimize the number of disputes that reach the grievance process.
9. **Elements of Due Process**: An activity in which the following procedural safeguards are required: (a) Adequate notice to the affected individual or organization; (b) Right of the individual or organization to be represented by counsel; (c) Opportunity for the individual to refute the evidence presented by the County or the basis of the action taken by the County including the right to confront and cross-examine witnesses and to present any affirmative legal or equitable defense which the individual or organization may have; (d) A decision on the merits.
10. **Facilitation**: A voluntary process involving the use of techniques to improve the flow of information and develop trust between the parties to a dispute. Involves a third party (facilitator) who, as in mediation, uses a process to assist the parties in reaching an agreement that is acceptable to the parties.
11. **Facilitator:** A third party who works with the parties to a dispute, providing direction to a process. A facilitator may be independent or may be drawn from one of the parties, but must maintain impartiality on the topics under discussion.
12. **Grantee:** Miami-Dade County.
13. **Grievance:** A complaint or dispute that has reached the stage where the affected party seeks a structured approach to its resolution.
14. **Grievant:** A person or entity seeking a structured resolution of a grievance.
15. **Hearing Officer:** shall mean a person selected in accordance with this policy to hear grievances and render a decision with respect thereto.

Miami-Dade County Ryan White Title I Grantee Grievance Procedures and Process

16. **Individual**: An adult person (or persons), organization, agency, or governmental entity that is the direct object of the County's action, ruling or policy.

17. **Mediation:** A voluntary process in which an impartial and usually independent third party assists parties to a dispute in reaching an acceptable resolution to the issues in the dispute. Mediation may involve meetings held by the mediator with the parties together and separately. The results of a mediation can become binding on the parties if the parties agree to make it binding.

18. **Mediation/arbitration (med/arb):** A mixed approach in which parties agree to mediate their differences and submit those issues that cannot be resolved through mediation to arbitration. This technique helps to narrow the issues submitted to arbitration. The parties may agree to use separate mediators and arbitrators for different stages of the process, or they may use the same third party.

19. **Mediator:** A trained, impartial and usually independent third party selected by the parties to the dispute or by another entity to help the parties reach an agreement on a determined set of issues.

20. **Neutral:** An independent third party, including a mediator or arbitrator, selected to resolve a dispute or grievance.

21. **Non-binding:** Techniques in which the parties to a dispute attempt to reach an agreement. The results must be agreed to by both parties; results are not imposed by the third party as they are in binding arbitration or in a judicial proceeding.

22. **Organization:** An organized provider, consumer group, advocacy or service organization under incorporation with an adopted set of by-laws and elected officers.

23. **Party:** One of the participants in the grievance process. This includes the grievant (or person or group) who brings the grievance action, and the person or group against which the grievance is brought.

24. **Remedy:** Relief or result sought by a grievant in bringing a grievance. It can include money damages or a process change. For the purpose of these procedures, any remedies that result from this process will be prospective only.

Miami-Dade County Ryan White Title I Grantee Grievance Procedures and Process

25. **Standing:** The eligibility of an individual or entity to bring a grievance. In the case of locally drafted grievance procedures under the CARE Act reauthorization, standing refers to a directly affected individual or entity challenging a decision with respect to funding.

26. **Third Party:** An independent or impartial person, including a facilitator, mediator, ombudsman or arbitrator, selected to resolve a dispute or grievance or assist the parties in resolving a dispute or grievance.

27. **With respect to funding:** The County's contracting and award process and allocations or selection of contractors and their awards.

ARTICLE III

THE GRIEVANCE PROCESS

A. REQUESTS FOR GRIEVANCES AND NOTICE OF HEARING

1. **Requests for Grievance:** A grievant shall have thirty (30) working days from the date of the alleged incident giving rise to the grievance to file a written grievance with the County. The grievance shall set forth with particularity the dispute to be addressed by the County, Mediator, Hearing Officer or Arbitrator. The grievant is required to complete and submit Form 1, attached hereto. All grievances which are timely filed are deemed sufficient if made in writing and delivered personally or sent by certified mail, return receipt requested, postage prepaid, to the County at the following address: (or to such other address to be determined by the County):

Miami-Dade County
c/o Office of Management and Budget
140 West Flagler Street, Room 1604
Miami, Florida 33130-1563
Attn: Yocasta Juliao, Project Director

Failure to timely file said grievance shall result in a refusal by the County, Mediator, Hearing Officer or Arbitrator to consider the merits of the grievance. A grievant's failure to timely file Form 1 shall result in and be deemed a waiver of any and all rights afforded herein.

Miami-Dade County Ryan White Title I Grantee Grievance Procedures and Process

2. **Determination of Ripeness and Jurisdiction:** All grievances shall be reviewed by the Office of Management and Budget, in consultation with the County Attorney's Office, to determine the ripeness of the grievance and/or jurisdictional issues. In the event it is determined that the grievance is not ripe or that there is a lack of jurisdiction, the Office of Management and Budget shall notify the grievant in writing within ten (10) days of receipt of the grievance. A copy of said notice shall be sent to the County Attorney.

3. **Notice of Hearing:** At least twenty (20) days prior to any procedure described below, the County shall deliver a notice of hearing to the parties by personal service or certified mail. Such notice shall include the date, time and place at which the hearing is held.

4. **Fees:** As a condition of initiating any grievance within the scope of this grievance process, the grievant shall present to the Clerk of the Board a nonrefundable filing fee payable to the Clerk of the Board in accordance with the schedule provided below.

Contract Award Amount	Filing Fee
$25,001-$100,000	$ 500
$100,001-$500,000	$1,000
$500,001-$5 million	$3,000
Over $5 million	$5,000

Filing fees, or any other monies received as payment of protest costs, shall be deposited in a special account administered by the Clerk of the Board and shall be used by the Clerk solely for the purpose of defraying the cost of the mediator, hearing examiner and/or arbitrator and the Clerk's costs of administering the County's grievance program. If, at any given time, there are insufficient funds available in said special account to pay said costs the requesting department shall be responsible for reimbursement of any shortage to the Clerk of the Board.

B. TYPES OF GRIEVANCES COVERED BY THE PROCEDURE AND WHO MAY BRING A GRIEVANCE

1. Types of County Grievances

The following County processes may be grieved:

Miami-Dade County Ryan White Title I Grantee Grievance Procedures and Process

a. Disputes concerning the County's contracting and award process; and the County's allocations or selection of contractors and their awards.

2. Who May Grieve

Providers eligible to receive Ryan White Title I funding within the Miami-Dade County EMA or who have submitted a rejected proposal pursuant to the County's Request for Proposal process may file a grievance with the County.

C. GRIEVANCE INITIATION AND PRELIMINARY DIRECT MEETING

(Maximum amount of time to complete once initiated: twenty (20) working days)

Throughout the grievance process (including both non-binding and binding resolution), the following is considered to be public information: the specific process being grieved, the identity of the party submitting the grievance, and the resolution agreed upon. However, any other information shared during the grievance process is considered confidential and shall not be shared with parties who are not involved in the process.

(1) Step 1 –Submittal of Grievance

Individuals or entities wishing to grieve a County process must: (a) complete the Grievance Form; (b) submit it in accordance with the provisions set forth in Article III within 30 working days after the completion of the County process that is the subject of the grievance; (c) each grievance requires a separate grievance form.

(2) Step 2 –Review for Allowance

The County will distribute a copy of the submitted Grievance Form to members of a Grievance Committee, which must include at least one (1) person living with HIV/AIDS, created under these procedures.

The committee members must be:

(a) Familiar with the work of the County and the HIV/AIDS service delivery system; and

(b) Independent of the specific process that is the subject of the grievance and free of direct interest in the outcome of the process being grieved.

Miami-Dade County Ryan White Title I Grantee Grievance Procedures and Process

The Grievance Committee will determine whether the grievance is allowable as defined by section B(1) of these Procedures.

Within ten (10) working days from its submittal date, the grievant must be notified in writing whether or not the grievance is allowable.

(3) Step 3 –Direct Meeting

Within 10 working days after Step 2 is completed, the grievant will meet with the County's representative most appropriate to address the concerns of the grievant. This meeting will take place at a location agreed to by all parties. The purpose of the direct meeting is to address the concerns of the grievant and, if possible, make mutually satisfactory adjustments to the grieved process for future implementation. The grievant shall bear his/her or its own expenses with respect to Paragraph C, Steps 1, 2 and 3 of the Procedures for Grievances.

D. NON-BINDING MEDIATION
(Maximum amount of time to complete: 20 days)

(1) Step 4 –Selection of Mediator

If resolution of the grievance is not achieved through Step 3, a mediator will be chosen. Selection of this mediator must take place **within ten (10) working days** of the end of Step 3.

The mediator must be:

(a) Independent of the specific processes that is the subject of the grievance;
(b) Free of direct interest in the outcome of the process being grieved, and
(c) Approved by both the grievant and the County before beginning his/her work.

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In order to expedite the Grievance Process, the County will create and maintain a pool of at least five (5) persons willing to serve as mediators in this process. These persons are not to be employees or agents of the County and may be from outside the geographic area of the EMA.

The grievant and the County shall agree as to a date, place and time for meeting with the mediator. The grievant shall bear his/her or its own expenses. The County shall bear expenses of any County members. The expenses of the mediator shall be borne one-half by the County and one-half by the grievant. The grievant's half of the estimated costs of the mediator must be paid directly to the mediator before mediation begins.

The parties shall set the per diem rate of the mediator. No County employee or agent shall receive such per diem service on his/her service. Each party shall be responsible for producing his/her or its own witnesses and shall bear expenses for same.

(2) Step 5 –Mediation

Once the mediator is selected, mediation will take place within a period of ten **(10) working days** at a location agreed to by both parties. During this time, the mediator is responsible for:

(a) Investigating the grievance;
(b) Mediating between the County and the Grievant; and
(c) Pursuing a solution that is mutually satisfactory to both parties.

E. INFORMAL HEARING

(1) Step 6 – Hearing

a. When the County notifies the individual of an action the County shall also include in that notice that any grievance hearing requests shall be in accordance with the expedited grievance procedure.

b. The grievant shall have seven (7) calendar days from the date of the notice in which to file a written request for an informal expedited non-binding arbitration hearing to the County. The written request shall specify: (a) The reasons for the grievance, and; (b) The action or relief sought.

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Grievance Procedures and Process

c. The grievant shall NOT have the grievance informally discussed as outlined in Section C.

d. Within ten (10) days of receipt by the County of the grievant's request for a hearing, the Executive Committee or its designee shall notify the individual of the selection of a Hearing Officer. The individual has five (5) calendar days from the date of the notice to submit comments as to the selection of the Hearing Panel or Hearing Officer.

e. Upon the grievant's compliance with subsection 3 of this section, a hearing shall be scheduled by the Hearing Officer promptly for a time and place reasonably convenient to both the grievant and the County, not in excess of five (5) working days of the selection of the Hearing Officer. A written notification specifying the time, place and the procedures governing the hearing shall be delivered to the grievant and the appropriate County official.

f. The hearing shall be held before a Hearing Officer.

g. The grievant shall be afforded a fair hearing, which shall include: (a) The opportunity to examine before the grievance hearing any County documents, including records and regulations, that are directly relevant to the hearing. The grievant shall be allowed to copy any such document at the grievant's expense. If the County does not make the document available for examination upon request by the grievant, the County may not rely on such document at the grievance hearing; (b) The right to be represented by counsel or other person chosen as the grievant's representative, and to have such person make statements on the grievant's behalf; (c) The right to a public hearing; (d) The right to present evidence and arguments in support of the grievant's complaint, to controvert evidence relied on by the County, and to confront and cross-examine all witnesses upon whose testimony or information the County or project management relies; and (e) A decision based solely and exclusively upon the facts presented at the hearing.

h. The Hearing Officer may render a decision without proceeding with the hearing if the Hearing Officer determines that the issue has been previously decided in another proceeding.

i. Except in the case of an expedited grievance procedure, if the grievant or the County fails to appear at a scheduled hearing, the Hearing Officer may make a determination to postpone the hearing for not more than five (5) business days or may

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make a determination that the party has waived his right to a hearing. The Hearing Officer shall notify both the grievant and the County of the determination.

j. At the hearing, the grievant must first make a showing of an entitlement to the relief sought and thereafter the County must sustain the burden of justifying the County action or failure to act against which the complaint is directed.

k. **Conduct of the Hearing**: The hearing shall be conducted informally by the Hearing Officer and oral or documentary evidence pertinent to the facts and issues raised by the complaint may be received without regard to admissibility under the rules of evidence applicable to judicial proceedings. The Hearing Officer shall require the County, the grievant, counsel and other participants or spectators to conduct themselves in an orderly fashion. Failure to comply with the directions of the Hearing Officer to obtain order may result in exclusion from the proceedings or in a decision adverse to the interests of the disorderly party and granting or denial of the relief sought, as appropriate.

(1) Any party or Hearing Officer may call, examine and cross-examine witnesses, and introduce documentary and other evidence into the record. Upon offering an exhibit into evidence at a hearing, a party shall provide an original and four copies to the Hearing Officer, and simultaneously furnish copies to all parties.

(2) All relevant and material evidence, oral or written, may be received. Hearsay evidence shall be accorded such weight as the circumstances warrant. In its discretion, the Hearing Officer may exclude irrelevant, immaterial or unduly repetitious evidence. A party is entitled to resent his or her case by oral and documentary evidence, to submit rebuttal evidence, and to conduct cross-examination. Both parties may appear in person or through any duly authorized representative.

(3) The burden of persuasion, or duty of producing evidence to substantiate any allegation raised in the grievance, remains with the grievant in all hearings before the Hearing Officer.

l. The Hearing Officer shall open the hearing at the time and place specified in the notice of hearing, or soon thereafter as a Hearing Officer can be obtained. After a reasonable time, if it is determined by the Grievance Committee that no Hearing Officer

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can be obtained, the hearing shall be continued until such time as a Hearing Officer or Hearing Panel can be obtained.

m. Either party may request a continuance. A continuance may be granted solely at the discretion of the Hearing Officer.

n. The grievant or the County may arrange, in advance and at the expense of the party making the arrangement, for a transcript of the hearing. Any interested party may purchase a copy of such transcript.

o. The County must provide reasonable accommodation for persons with disabilities to participate in the hearing. Reasonable accommodation may include qualified sign language interpreters, readers, accessible locations, or attendants. If the grievant is visually impaired, any notice to the grievant, which is required under this section, must be in an accessible format.

p. The Hearing Officer shall prepare a written decision, together with the reasons therefore, within a reasonable time after the hearing, but not in excess of 7 business days for a standard hearing and not excess of three (3) business days in the case of an expedited grievance hearing. A copy of the decision shall be sent to the grievant and the County. The County shall retain a copy of the decision in the grievant's folder. A copy of such decision, with all names and identifying references deleted, shall also be maintained on file by the County and made available for inspection by a prospective grievant, his representative, or the Hearing Panel.

q. The decision of the Hearing Officer shall be binding on the County which shall take all actions, or refrain from any actions, necessary to carry out the decision unless the County determines within a reasonable time, not to exceed 30 days, and promptly notifies the grievant of its determination, that (a) The grievance does not concern County action or failure to act which adversely affect the grievant's rights, duties, welfare or status; (b) The decision of the Hearing Officer is contrary to applicable Federal, State or local law, regulations or requirements of the contract between the HRSA and the Miami-Dade County.

r. A decision by the Hearing Officer, or Board of Commissioners in favor of the County or which denies the relief requested by the grievant in whole or in part shall not constitute a waiver of, nor affect in any manner whatever, any rights the grievant may have to a trial de novo or judicial review in any judicial proceedings, which may thereafter be brought in the matter.

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s. **Expenses:** The County shall bear the administrative costs of the hearing as described above, including location costs and any costs related to the Hearing Officer. All other expenses, including the expense of counsel for the grievant, personal transportation, and meals shall be borne by the grievant.

F. BINDING ARBITRATION

(Maximum amount of time to complete once initiated: 20 working days)

If a mutually satisfactory resolution of the grievance is not achieved within the period allotted for mediation, the grievant may seek to resolve the grievance through binding arbitration.

(1) Step 7 –Submittal of Request for Binding Arbitration

The grievant must submit a completed Request for Binding Arbitration Form to the County **within ten (10) working days** of the conclusion of mediation. **Within five (5) working days** of submittal of the Request for Binding Arbitration For, the County's representative will (a) notify the County that a Request for Binding Arbitration Form has been submitted; (b) notify the County's contractor for arbitration of the request; and (c) notify the grievant in writing whether or not the grievance is eligible for binding arbitration.

(The request for Binding Arbitration will be considered eligible as long as steps through 5 have already been completed).

(2) Step 7 –Arbitration

Within five (5) working days from the date the Request for Binding Arbitration Form is submitted, the third-party arbitrator will forward to both the grievant and the County's representative previously established rules of arbitration, which will be followed through the remainder of the arbitration process. The arbitration process will include steps which the arbitrator deems necessary to reach a decision, according to the arbitrator's previously established rules, provided such rules are satisfactory to both parties. The grievant and the County shall agree as to a date, place and time for meeting with the arbitrator. The grievant shall bear his/her or its own expenses. The County shall bear expenses of any County's employees or agents. The expenses of the arbitrator shall be borne one-half by the County and one-half by the grievant. The grievant' half of the estimated costs of the arbitrator must be paid directly to the arbitrator before arbitration begins. The parties

Miami-Dade County Ryan White Title I Grantee Grievance Procedures and Process

shall set the per diem rate of the arbitrator. No County member shall receive such per diem service on his/her service. Each party shall be responsible for producing his/her or its own witnesses and shall bear expenses for same. The arbitrator must complete the arbitration process and provide a binding decision for future implementation **within fifteen (15) working days** of notification.

ARTICLE IV

SUNSHINE LAWS

All meetings concerning any grievance filed under these Procedures must comply with Florida's Government in the Sunshine laws and Article XII of the Bylaws of the County. Public notice of all meetings shall be given in accordance with State and local requirements. Meetings shall be open to the public. Written notice shall be given at least 13 days in advance of any regularly scheduled County meeting date.

ARTICLE V

AMENDMENTS

Any amendments that need to be made to these procedures shall only be made after a 30-day public comment period is allowed and then only after the County has considered the comments received.

Acknowledgement of Receipt of Grievance Procedures:

IN WITNESS WHEREOF, the undersigned hereby acknowledges that he/she has received a copy of this procedure and has read or has had read to him/her the procedures outlined in this Grievance Procedure.

_____

Miami-Dade County, Florida

RFP No. RW1401
ATTACHMENT 6

LOCAL BUSINESS PREFERENCE

Proposals submitted for this solicitation will be reviewed by the Evaluation/Selection Committee for Local Business Preference in accordance with Miami-Dade County Ordinance 94-166 as amended by Ordinance 01-21 and Resolution No. R-514-02, defining local business preference. A local business is defined as a proposer, which has a valid occupational license issued by Miami-Dade or Broward County at least one year prior to the proposal due date, to do business in Miami-Dade or Broward County and that authorizes the proposer to provide the goods, services or construction to be purchased; and, has a physical business address located within the limits of Miami-Dade and Broward County from which the proposer operates or performs business. (A Post Office Box is unacceptable.) **If the Proposer is a local firm as defined above, the Proposer shall submit a copy of its Miami-Dade or Broward Occupational License, which shall have been in effect one year prior to the proposal due date; and, evidence in the form of a lease or other such documentation, that is proof that the Proposer is located in Miami-Dade or Broward County.**

PLEASE CHECK IF APPLYING FOR LOCAL PREFERENCE YES ☐ NO ☐

Proposer: _____

Federal Employer Identification Number: _____

Contact Name: _____

Address: _____

City/State/Zip: _____

Telephone: (_____)_____ Fax: (_____)_____

I hereby certify that to the best of my knowledge and belief all the foregoing facts are true and correct.

Signature of Authorized Representative: _____

Title: _____

Date: _____

STATE OF _____
COUNTY OF _____

SUBSCRIBED AND SWORN TO (or affirmed) before me on _____ (Date),
by _____ (Affiant). He/She is personally known to me or
has presented _____ (Type of Identification) as identification.

_____ _____
(Signature of Notary) (Serial Number)

_____ _____
(Print or Stamp Name of Notary) (Expiration Date)

Notary Public _____ Notary Seal
(State)

Form A-5 Rev. 10/02

RFP No. RW1401
ATTACHMENT 7

SUBCONTRACTOR/SUPPLIER LISTING
(Ordinance 97-104)

Firm Name of Prime Contractor/Proposer _____ **RFP Name** _____

RFP Number _____

This form, or a comparable listing meeting the requirements of Ordinance No. 97-104, **MUST** be completed by all bidders and proposers on County contracts for purchase of supplies, materials or services, including professional services which involve expenditures of $100,000 or more, and all bidders and proposers on County or Public Health Trust construction contracts which involve expenditures of $100,000 or more. **This form, or a comparable listing meeting the requirements of Ordinance No. 97-104, must be completed and submitted even though the bidder or proposer will not utilize subcontractors or suppliers on the contract. The bidder or proposer should enter the word "NONE" under the appropriate heading of Form A-7.1 in those instances where no subcontractors or suppliers will be used on the contract.** A bidder or proposer who is awarded the contract shall not change or substitute first tier subcontractors or direct suppliers or the portions of the contract work to be performed or materials to be supplied from those identified except upon written approval of the County.

Business Name and Address of First Tier Subcontractor/Subconsultant	Principal Owner	Scope of Work to be Performed by Subcontractor/Subconsultant	(Principal Owner) Gender	Race
Business Name and Address of Direct Supplier	**Principal Owner**	**Supplies/Materials/Services to be Provided by Supplier**	**(Principal Owner) Gender**	**Race**

I certify that the representations contained in this Subcontractor/Supplier Listing are to the best of my knowledge true and accurate.

Signature of Proposer's Authorized Representative	Print Name	Print Title	Date

(Duplicate if additional space is needed)

FORM A-7.2

FAIR SUBCONTRACTING POLICIES
(Ordinance 97-35)

FAIR SUBCONTRACTING PRACTICES

In compliance with Miami-Dade County Ordinance 97-35, the Proposer submits the following detailed statement of its policies and procedures for awarding subcontracts:

I hereby certify that the foregoing information is true, correct and complete.

Signature of Authorized Representative: _____

Title: _____ Date: _____

Firm Name: _____ Fed. ID No. _____

Address: _____ City/State/Zip: _____

Telephone: (____)_____ Fax: (____)_____

Miami-Dade County, Florida

RFP No. RW1401
ATTACHMENT 9

AFFIRMATIVE ACTION PLAN/PROCUREMENT POLICY AFFIDAVIT (Ordinance 98-30)

I being duly first sworn, upon oath deposes that _____ has a current Affirmative Action Plan
Name of Company

and/or Procurement Policy, as required by Ordinance 98-30, processed and approved for filing with the Miami-Dade County Department of Business Development (DBD) under the file No. _____ and the expiration date of _____ .

Witness: _____ _____
Signature Signature

Witness: _____ By: _____
Signature Legal Name and Title

The foregoing instrument was acknowledged before me this _____ day of _____, 20 _____

FOR AN INDIVIDUAL ACTING IN HIS OWN RIGHT:
By: _____

FOR A CORPORATION, PARTNERSHIP OR JOINT VENTURE:

By: _____ having the title of _____

with _____.

☐ a _____ corporation ☐ partnership ☐ joint venture.

☐ **DOES NOT APPLY-MY COMPANY'S REVENUE IS LESS THAN $5 MILLION**

_____ _____
Signature Date

PLEASE NOTE:
Ordinance 82-37 requires that all property licensed architectural, engineering, landscape architectural, and land surveyor, have an affirmative action plan on file with the County.

Ordinance 98-30 requires that firms that have annual gross revenue in excess of five (5) million dollars have an affirmative action plan and procurement policy on file with the County. If your firm does not have an annual gross revenue in excess of five (5) million dollars: check the above, sign and return this affidavit only. Firms that have a Board of Directors that are representative of the population make-up of the nation are exempt and must complete and return THE EXEMPTION AFFIDAVIT only.

For questions regarding these requirements, please contact the Miami-Dade County Department of Business Development at 305-349-5960.

THIS AFFIDAVIT MUST BE PROPERLY EXECUTED BY THE BIDDER AND RETURNED TO:

MIAMI-DADE COUNTY
DEPARTMENT OF BUSINESS DEVELOPMENT
COURTHOUSE CENTER
175 NW 1ST AVENUE
28TH FLOOR
MIAMI, FLORIDA 33128

A-8.2 Rev. 3/2/00

AFFIRMATIVE ACTION PLAN EXEMPTION AFFIDAVIT (Ordinance 98-30)

Project No. _____
Project Name: _____

I being duly first sworn, upon deposes that _____ has a Board
Name of Company

of Directors which is representative of the population make-up of the nation and hereby claims exemption in accordance with the requirements of Ordinance 98-30. Said bidder has a current Board of Directors Disclosure form, as required by Ordinance 98-30, processed and approved for filing with the Miami-Dade County Department of Business Development (DBD) under the file No._____ and the expiration date of _____ .

Witness: _____ _____
Signature Signature

Witness: _____ By: _____
Signature Legal Name and Title

The foregoing instrument was acknowledged before me this _____ day of _____, 20 _____

FOR A CORPORATION, PARTNERSHIP OR JOINT VENTURE:

By: _____ having the title of _____

with _____.

☐ a _____ corporation ☐ partnership ☐ joint venture

PLEASE NOTE:

Ordinance 98-30 requires that firms that have annual gross revenues in excess of five (5) million dollars to have an affirmative action plan and Procurement Policy on file with the County. Firms that have Boards of Directors that are representative of the population make-up of the nation are exempt and must complete the affidavit.

For questions regarding these requirements contact the Miami-Dade County Department of Business Development at (305) 349-5960.

THIS EXEMPTION AFFIDAVIT MUST BE PROPERLY EXECUTED BY THE BIDDER AND RETURNED TO:

MIAMI-DADE COUNTY
DEPARTMENT OF BUSINESS DEVELOPMENT
COURTHOUSE CENTER
175 NW 1ST AVENUE
28TH FLOOR
MIAMI, FLORIDA 33128

PROPOSER'S AFFIDAVIT THAT MIAMI-DADE COUNTY TAXES, FEES AND PARKING TICKETS HAVE BEEN PAID
(Section 2-8.1(c) of the Code of Miami-Dade County, as amended by Ordinance No. 00-30)
and
THAT PROPOSER IS NOT IN ARREARS TO THE COUNTY
(Section 2-8.1(h) of the Code of Miami-Dade County, as amended by Ordinance No. 00-67)

I, _____, being first duly sworn, hereby state and certify that the foregoing statements are true and correct:

1. that I am the Proposer (if the Proposer is an individual), or the _____(fill in the title of the position held with the Proposer) of the Proposer.
2. that the Proposer has paid all delinquent and currently due fees or taxes(- including but not limited to, real and personal property taxes, utility taxes, and occupational taxes)collected in the normal course by the Miami-Dade County Tax Collector, and County issued parking tickets for vehicles registered in the name of the above proposer, have been paid.
3. that the Proposer is not in arrears in excess of the enforcement threshold under any contract, final non-appealable judgment, or lien with Miami-Dade County, or any of its agencies or instrumentalities, including the Public Health Trust, either directly or indirectly through a firm, corporation, partnership or joint venture in which the Proposer has a controlling financial interest For purposes hereof, the term "enforcement threshold" means any arrearage under any individual contract, non-appealable judgment, or lien with Miami-Dade County that exceeds $25,000 and has been delinquent for greater than 180 days. For purposes hereof, the term "controlling financial interest" means ownership, directly or indirectly, of ten per cent or more of the outstanding capital stock in any corporation, or a direct or indirect interest of ten per cent or more in a firm, partnership, or other business entity.

By: _____ _____ , 20 _____
Signature of Affiant Date

_____ __/__-__/__/__/__/__/__/__/__/__
Printed Name of Affiant and Tile Federal Employer Identification Number

_____
Printed Name of Firm

_____
Address of Firm

SCRIBED AND SWORN TO (or affirmed) before me this _____ day of_____, 20 ____.

by _____. He/She is personally known to me or has presented

_____ _____
Signature of Notary Serial Number

_____ _____
Print or Stamp Name of Notary Expiration Date

Notary Public – State of _____

Notary Seal

Code of Business Ethics

In accordance with Section 2-8.1(i) of the Miami-Dade County Code, each person or entity that seeks to do business with the County shall adopt a Code of Business Ethics ("Code") and shall, prior to execution of any contract between the contractor and the County, submit an affidavit stating that the contractor has adopted a Code that complies with the requirements of Section 2-8.1(i) of the Miami-Dade County Code. Any person or entity that fails to submit the required affidavit shall be ineligible for contract award. The Code of Business Ethics shall apply to all business that the contractor does with the County and shall, at a minimum, require that the contractor:

- Comply with all applicable governmental rules and regulations including, among others, the Miami-Dade County Conflict of Interest and Code of Ethics Ordinance and the False Claims Ordinance.
- Comply with all applicable rules and regulations regarding Disadvantaged Business Enterprises, Black Business Enterprises, Hispanic Business Enterprises and Women Business Enterprises (hereinafter collectively Minority Business Enterprises, "MBEs') and Community Small Business Enterprises (CSBE5) and shall specifically prohibit the following practices:

    - Pass-through Requirements. The Code shall prohibit pass-throughs whereby the prime firm requires that the MBE or CSBE firm accept payments as a MBE or CSBE and pass through those payments or a portion of those payments to another entity including, but not limited to the owner/operator of the prime firm;
    - Rental Space, Equipment or Flat Overhead Fee Requirements. The Code shall prohibit rental space requirements, equipment requirements, and/or flat overhead fee requirements, whereby the prime firm requires the MBE or CSBE firm to rent space or equipment from the prime firm or charges a flat overhead fee for the use of space, equipment, secretary, etc.;
    - Staffing Requirements. The Code shall prohibit the prime firm from mandating, as a condition to inclusion in the project, that a MBE or CSBE hire, fire, or promote certain individuals not employed by the prime firm, or utilize staff employed or previously employed by the prime firm.
    - MBE or CSBE staff utilization. The Code shall prohibit the prime firm from requiring the MBE or CSBE firm to provide more staff than is necessary and then utilizing the MBE or CSBE staff for other work to be performed by the prime firm.
    - Fraudulently creating, operating or representing MBE or CSBE. The Code shall prohibit a prime firm including, but not limited to, the owners/operators thereof from fraudulently creating, operating or representing an entity as a MBE or CSBE for purposes of qualifying for certification as a MBE or CSBE.

- The Code shall also require that on any contract where MBE or CSBE participation is purported, the contract shall specify essential terms including, but not limited to, a specific statement regarding the percent of participation planned for MBEs or CSBEs, the timing of payments and when the work is to be performed.

- The failure of a contractor to comply with its Code of Business Ethics shall render any contract between the contractor and the County voidable, and subject violators to debarment from future County work pursuant to Section 10-38(h)(2) of the Code. The Inspector General shall be authorized to investigate any alleged violation by a contractor of its Code of Business Ethics.

Miami-Dade County, Florida

RFP No. RW1401
ATTACHMENT 12

CODE OF BUSINESS ETHICS

[Section 2-8.1(i), Code of Miami-Dade County]

I, being duly sworn, hereby state and certify that this firm has adopted a Code of Business Ethics that is fully compliant with the requirements of Section 2-8.1(1) of the Code of Miami-Dade County as amended. I further acknowledge that failure to comply with the adopted Code of Business Ethics shall render any contract with Miami-Dade County voidable, and subject this firm to debarment from County work pursuant to Section 10-38(h)(2) of the Code of Miami-Dade County as amended. I further acknowledge that failure to submit this affidavit shall render this firm ineligible for contract award.

By: _____ _____ 20 _____
Signature of Affiant Date

_____ _____
Printed Name and Title of Affiant Federal Employer Identification Number

_____
Printed Name of Firm

_____
Address of Firm

SUBSCRIBED AND SWORN TO (of affirmed) before me this _____day of_____ ,20 ____

He/She is personally known to me or has presented_____ as identification.
Type of Identification

_____ _____
Signature of Notary Serial Number

_____ _____
Print or Stamped Name of Notary Expiration Date

Notary Public, State of _____

A-12 Rev. 7/12/01

Miami-Dade County, Florida

RFP No. RW1401
ATTACHMENT 13

MIAMI-DADE COUNTY
DOMESTIC VIOLENCE LEAVE AFFIDAVIT

(County Ordinance No 99-5 and Resolution No. R-185-00)

I, _____, being first duly sworn state:
Affiant

That in compliance with Ordinance No. 99-5, Resolution No. R-185-00 and the Code of Miami-Dade County, Florida, the following information is provided and is in compliance with all items in the aforementioned legislation.

As an employer having, in the regular course of business, fifty (50) or more employees working in Miami-Dade County for each working day during each of twenty (20) or more calendar work weeks in the current or preceding calendar year, do hereby certify to be in compliance with the Domestic Leave Ordinance, codified at 11A-60 et. seq., of the Miami-Dade County Code, and that the obligation to provide domestic violence leave to employees shall be a contractual obligation.

By: _____ _____ 200 ___
Signature of Affiant Date

_____ ___/___-___/___/___/___/___/___/___/___/
Printed Name of Affiant and Title Federal Employer Identification Number

_____
Printed Name of Firm

_____
Address of Firm

SUBSCRIBED AND SWORN TO (or affirmed) before me this _____ day of _____, 200 ___

He/She is personally known to me or has presented _____ as identification.
Type of Identification

_____ _____
Signature of Notary Serial Number

_____ _____
Print or Stamp Name of Notary Expiration Date

Notary Public – State of _____

Notary Seal

a:\family leave affidavit.doc
REVISED 04/01/98

Miami-Dade County, Florida

RFP No. RW1401
ATTACHMENT 14

DISABILITY NONDISCRIMINATION AFFIDAVIT

CONTRACT REFERENCE: _____

NAME OF FIRM, CORPORATION, OR ORGANIZATION: _____

AUTHORIZED AGENT COMPLETING AFFIDAVIT: _____

POSITION: _____ PHONE NUMBER: (____) _____

I, _____, being duly first sworn state:

That the above named firm, corporation or organization is in compliance with and agrees to continue to comply with, and assure that any subcontractor, or third party contractor under this project complies with all applicable requirements of the laws listed below including, but not limited to, those provisions pertaining to employment, provision of programs and services, transportation, communications, access to facilities, renovations, and new construction.

The Americans with Disabilities Act of 1990 (ADA), Pub. L. 101-336, 104 Stat 327, 42 U.S.C. 12101-12213 and 47 U.S.C. Sections 225 and 611 including Title I, Employment; Title II, Public Services; Title III, Public Accommodations and Services Operated by Private Entities; Title IV, Telecommunications; and Title V, Miscellaneous Provisions.

The Rehabilitation Act of 1973, 29 U.S.C. Section 794

The Federal Transit Act, as amended 49 U.S.C. Section 1612

The Fair Housing Act as amended, 42 U.S.C. Section 3601-3631

_____
Signature

_____
Date

SUBSCRIBED AND SWORN TO (or affirmed) before me on _____
(Date)

by _____ (Affiant). He/She is personally known to me or has presented _____ as identification.

_____
(Type of Identification)

_____ _____
(Signature of Notary) (Serial Number)

_____ _____
(Print or Stamp Name of Notary) (Expiration Date)

Notary Public _____ Notary Seal (State)

A-4 - Rev. 1/2/98

RFP No. RW1401
ATTACHMENT 15

LINE ITEM BUDGET FORM

RFP No. RW 1401
ATTACHMENT 15

This form is to be used for all services including those that are reimbursed based on either a unit cost or multiplier.

Instructions for completing the Line Item Budget Form are provided on the reverse side of this document.

Organization	Service Category	Budget Period

Object Class Categories	Ryan White		Other Funding					
DIRECT COSTS:	Title I Service Costs	Title I Indirect/Admin. Costs*	Other Title I Funds	All Other Federal Funds	City and/or State	General Oper./ Private	Total Cost For Budget Period	Percent Charged to Title I
Personnel								
1. Position								
Fringes								
2. Position								
Fringes								
3. Position								
Fringes								
4. Position								
Fringes								
5. Position								
Fringes								
6. Position								
Fringes								
7. Position								
Fringes								
Travel								
Supplies								
Equipment								
Contractual:								
Other Direct Costs:								
Other Direct Costs:								
Other Direct Costs:								
Other Direct Costs:								
Other Indirect Costs:								
Other Indirect Costs:								
TOTAL								
TOTAL AMOUNT REQUESTED								

*Total not to exceed 10% of Contract Award

Instructions for Completing
Line Item Budget Form

1. In the box titled **"Organization,"** please indicate the full legal name of the proposing organization.

2. In the box titled **"Service Category,"** please indicate the name of the service category that the proposing organization will provide with Ryan White Title I funding if awarded the full amount of its request.

3. In the box titled **"Budget Period,"** please indicate the time period **(mm/dd/yy - mm/dd/yy)** for which the organization will allocate funds awarded to provide the service identified above.

4. In the spaces provided under the column labeled **"Object Class Categories," first,** list all proposed direct service personnel and fringe benefits for each position. **Next,** list all proposed indirect/administrative personnel and fringe benefits. For all staff listed, indicate their position title, first initial, last name, and the percent at which the fringe benefits are calculated. **Then,** list travel for direct service personnel, direct service supplies, direct service equipment, contractual direct services, and any other direct costs (please see below for more information regarding allowable direct costs).

5. In the column labeled **"Title I Service Costs,"** please indicate, for this service category only, the amount for each line item to be funded by Title I as a direct cost. In the next column labeled **"Title I Indirect/Administrative Costs"** identify the amount allocated, for this service category only, for each specific line item listed as an indirect/administrative cost, if applicable.

6. In the columns to the right labeled **"Other Funding"**, indicate all other funding sources which are supporting these line items (i.e., Other Title I, Title II, HOPWA, local government funding, state funding, other federal funding, fees, contributions, general operating funds, etc.), where appropriate. Where the time periods overlap, if any line item under any other Title I funded service category, from any Title I contract (i.e., Continuation, Amendments, and New) is also listed under this budget, the proposing organization must include this contribution as "Other Title I" funds. For all other funding, be sure to calculate (prorate) the contribution from other sources based on the time period indicated on this budget.

7. In the last two columns, for this service category only, indicate the **total cost to your organization** for each line item for the budget period indicated and **the percentage** of each line item to be charged to Ryan White Title I (i.e., for each direct service line item, the percent charged to Title I, for this service category only, equals the amount listed as a "Title I Service Cost" divided by the amount identified as the **"Total Cost for Budget Period".** Similarly, for indirect line items, the percent charged to Title I, for this service category only, equals the amount listed as a "Title I Indirect/Administrative Costs" divided by the amount identified as the "Total Cost for Budget Period.")

8. In the column labeled **"Title I Indirect/Administrative Costs," please indicate the amount of indirect/overhead/administrative costs covered by Title I for each applicable line item (i.e. personnel, travel, supplies, equipment, or other indirect line item, etc.)**. The total amount of these costs under the column labeled "Title I Indirect/Administrative Costs" cannot exceed 10% of the total contract award. For example, if the total amount of funds being requested is $10,000, then the total for the "Title I Indirect/Administrative Costs" column may not exceed $1,000 (10% of the $10,000 being requested). **Due to Federal requirements, a detailed breakdown of individual indirect/administrative expenses is required; except for agencies with a Federally approved indirect cost rate, in which case a copy of the "Rate Agreement" must be included as part of their submission.**

9. Indicate the Total for each column in the space provided.

10. Indicate the Total Amount Request (i.e., the sum of "Title I Service Costs" and "Title I Indirect/Administrative Costs").

NOTE: FOR A LISTING OF ALLOWABLE DIRECT COSTS BY SERVICE CATEGORY, PLEASE SEE THE BUDGET JUSTIFICATION INSTRUCTIONS.

RYAN WHITE TITLE I PROGRAM INSTRUCTIONS FOR PREPARING A BUDGET JUSTIFICATION

(NOTE: THE FOLLOWING INSTRUCTIONS HAVE BEEN REVISED. PLEASE REVIEW THEM CAREFULLY.)

A budget justification **MUST** be submitted along with **each** categorical (line item) budget explaining the association of each expenditure to a Title I service program in relation to the service provider's total expenditures. Budget justifications **MUST** be specific, concise, and reflective of the budget period. The following guidelines **MUST** be followed when preparing a budget justification:

- **IMPORTANT: Please be advised, due to Federal requirements all costs (direct and indirect) must be presented on the budget form using the standard line item categories of personnel, fringe benefits, supplies, equipment and other. In addition, the budget narrative must include a justification for each line item. A total dollar amount for indirect charges without a detailed breakdown of individual expenses will no longer be acceptable.** In general, the percentage charged to Title I for any individual indirect cost may not exceed the percentage of clients, based on your organization's total client population, who receive the specific service for which the budget is being presented. For example, the total enrollment for ABC Organization is 500 clients; approximately 20% of the clients are enrolled in the Title I case management program, therefore the percentage of individual indirect costs charged to Title I under the case management budget may not exceed 20%. However, the total amount of all indirect costs may not exceed 10%. **Indirect expenses that do not conform to this standard policy will be reviewed in relation to their corresponding justification and adjusted, if necessary, during the contract negotiation process.**

Budget Period

- The **budget period** should be indicative of the time period in which the service provider can realistically spend the amount awarded for each service category. However, the service provider must continue to provide services to Title I clients throughout the contract period. The service provider may request additional Title I funds through two processes: reallocation of unspent dollars or through a competitive bid process (i.e., Request for Proposals).

Direct costs

- Direct costs are those that can be associated with the provision of services directly to the client. Direct service personnel are those who actually provide service directly to the client. Personnel who complete paperwork for billing and record keeping purposes (with the exception of case managers) are **NOT** considered direct costs. Similarly, supervisory and administrative personnel are **NOT** considered direct costs.

- Other allowable direct costs are those items or services that are utilized by direct service personnel or by the clients directly. **The following are examples of other allowable direct costs, by service category:**

✓ **Outpatient Medical Care & Minority AIDS Initiative (MAI) Outpatient Medical Care**

All Physicians, Nurses, Physician's Assistants, Nurse Practitioner, Medical Assistants, Dieticians/Nutritionists, lab tests, medical supplies, immunizations, radiology, P.P.D. costs, medical waste disposal, and beepers for Physicians. Malpractice insurance **ONLY** if it is indicated in the budget justification as such and is indicated as malpractice insurance for individual direct medical personnel listed in the budget.

✓ **Prescription Drugs**

Cost of actual medications and related supplies necessary for the use of drugs, Pharmacists, and Pharmacist Techs. Consumable medical equipment and supplies required for administering prescription drugs.

✓ **Case Management / Peer Education Support Network & MAI Case Management /PESN**

Case Managers, Peer Educators, phones, beepers (if they are specified for the case managers only), fax (if it is specified as being utilized only for the case management services only), travel reimbursement for the case managers (to and from the clients' homes), and paper (due to the paper intensive nature of case management services and only if it is identified in the budget separately from other general office supplies).

✓ **Substance Abuse Counseling - Residential**

Counselors, food for the clients, rent (for the housing unit in which the clients reside), psychiatric services, Physicians, Nurses, medical supplies, transportation for the clients to and from medical and/or other social service appointments, and regular drug testing.

Cost of food items, packaging material, informational material used to educate clients on nutritional issues, salaries and fringe benefits for personnel responsible for assisting or delivering food to the clients, and cost of vans used to deliver food or pick up food.

✓ **Outreach Services & MAI Outreach Services**

Outreach Workers' salaries and benefits, informational material on available HIV/AIDS services, telephone expenses (if related to Title I outreach services), beepers for Outreach Workers, fax (if it is utilized only for Title I outreach services), travel reimbursement for the Outreach Workers, and paper utilized in Title I outreach services (only if it is identified in the budget separately from other general office supplies).

✓ **AIDS Insurance Continuation Program**

Amount used for assistance to clients.

✓ **Insurance Deductible**

Amount used for assistance to clients.

✓ **Prescription Drugs Co-Payments & Co-Insurance**

Amount used for assistance to clients.

- In the **opening paragraph of the Budget Justification**, service providers **MUST** indicate the percentage of clients funded by Title I relative to the entire client population served that will be served during the contract period. Also, please indicate the length (or dates) of the budget period. For example, Agency ABC serves a total client population of 200 clients. It is estimated that Agency ABC will serve approximately 150 (75%) of these clients through Title I case management/PESN services during the 6-month budget period.

- **Direct Service Personnel** expenditures **MUST** be explained by including a brief description of the role of identified staff in the provision of Title I services and the percentage of their salary charged to the Title I budget. Service providers **MUST** justify the percentage charged to Title I by indicating the amount of time individual staff members contribute to the Title I program. For hourly or per diem employees, the rate per hour and/or per day **MUST** be indicated, as well as the number of hours of work per day/week/month. The methodology utilized by the service provider to arrive at the amount and percentages charged to Title I **MUST** be clearly explained.

- A breakdown of **fringe benefits** (including percentages) for each direct service position **MUST** be included as part of the justification for each position.

- **Travel** is only allowable for direct service staff and the reasons for travel **MUST** be explained and justified. The number of miles and cost per mile **MUST** also be indicated (the maximum charge per mile as per Miami-Dade County regulations is $0.29 per mile). The methodology utilized by the service provider to arrive at the amount and percentages charged to Title I **MUST** be clearly explained.

- **Supplies** are allowable only for the direct provision of services to the clients or for use by direct service personnel in the provision of direct services to clients. These costs **MUST** be described in detail and the amounts, percentages, and need for each cost **MUST** be justified. If necessary, these supplies may be listed as separate line items in the rows labeled "other direct costs." If separately listing the supply item, please clearly and briefly list the name or type of supply (e.g., Other Direct Costs: Paper). The methodology utilized by the service provider to arrive at the amount and percentages charged to Title I **MUST** be clearly explained.

- **Equipment** is allowable if it is utilized in the direct provision of services to the client. The type of equipment **MUST** be listed and its use for the Title I program **MUST** be described and justified. The methodology utilized by the service provider to arrive at the amount and percentages charged to Title I must be clearly explained. (An inventory of equipment purchases that are >$750 per individual item must be maintained by the service provider and reported annually to the Miami-Dade County, Office of Management and Budget.)

- Payments for **Contractual** services such as per-diem doctors, dentists, nurses, home health care personnel, **MUST** be specified by providing a description of hourly rates, per visit charges, or procedure costs. This explanation **MUST** also indicate the number of individuals involved in the Title I program who would fall under this category and the reasons why Title I funds are being used to cover this expense.

- **Generic line items, such as "Miscellaneous," will NOT be accepted.** Each line item **MUST** be clearly identified and adequately justified. If a line item is composed of several related costs, each cost **MUST** be itemized as part of the justification for that item.

- **Other costs may be considered as direct if they are justified properly and approved by Miami-Dade County.** The relation to the direct provision of Title I services must be described as well as the methodology utilized by the service provider to arrive at the amount and percentages charged to Title I.

Indirect/Administrative Costs

- Expenses included in the **"Indirect/Administrative Cost"** category **MUST** be individually listed in the budget justification. Please indicate the amount of indirect/overhead/administrative costs covered by Title I for each applicable line item (i.e., personnel, travel, supplies, equipment, etc.).

- The total charge for indirect costs may **NOT** exceed 10% of the total Title I funding for the budgeted service.

- Indirect/Administrative costs **MUST** be specified under the "Title I Indirect/Administrative Costs" column utilizing these objects class categories.

- **IMPORTANT: Due to Federal requirements, a detailed breakdown of all indirect costs MUST be included on the budget form (except for agencies with a Federally approved indirect cost rate, in which case a copy of the "Rate Agreement" MUST be included as part of their submission).**

THE MIAMI-DADE COUNTY VENDOR INFORMATION CENTER ("VIC")
IS LOCATED AT:

111 N.W. 1ST STREET, SUITE 112 (GROUND FLOOR)
MIAMI, FLORIDA 33128
(305) 375-5773

THE VIC PROVDIES INFORMATION AND ASSISTANCE IN:

- *DOING BUSINESS WITH MIAMI-DADE COUNTY*
- *VENDOR REGISTRATION AND CERTIFICATION*
- *CURRENT CONTRACTING OPPORTUNITIES COUNTYWIDE*

DEPARTMENT OF PROCUREMENT MANAGEMENT
DEPARTMENT OF BUSINESS DEVELOPMENT

RFP No. RW1401
ATTACHMENT 18

2004 FEDERAL POVERTY GUIDELINES
Annual Income Ranges

Family Size	A <100%	B 101-150%	C 151-200%	D 201-250%	E 251-300%	F >300%
1	< or equal to $9,310 - $9,402	$9,403 - $13,965	$14,058 - $18,620	$18,713 - $23,275	$23,368 - $27,930	$27,930 +
2	< or equal to $12,490 - $12,614	$12,615 - $18,735	$18,860 - $24,980	$25,105 - $31,225	$31,350 - $37,470	$37,470 +
3	< or equal to $15,670 - $15,826	$15,827 - $23,505	$23,662 - $31,340	$31,497 - $39,175	$39,332 - $47,010	$47,010 +
4	< or equal to $18,850 - $19,038	$19,039 - $28,275	$28,464 - $37,700	$37,889 - $47,125	$47,314 - $56,550	$56,550 +
5	< or equal to $22,030 - $22,249	$22,250 - $33,045	$33,265 - $44,060	$44,280 - $55,075	$55,295 - $66,090	$66,090 +
6	< or equal to $25,210 - $25,461	$25,462 - $37,815	$38,067 - $50,420	$50,672 - $63,025	$63,277 - $75,630	$75,630 +
7	< or equal to $28,390 - $28,673	$28,674 - $42,585	$42,869 - $56,780	$57,064 - $70,975	$71,259 - $85,170	$85,170 +
8	< or equal to $31,570 - $31,885	$31,886 - $47,355	$47,671 - $63,140	$63,456 - $78,925	$79,241 - $94,710	$94,710 +
9	< or equal to $34,750 - $35,097	$35,098 - $52,125	$52,473 - $69,500	$69,848 - $86,875	$87,223 - $104,250	$104,250 +
10	< or equal to $37,930 - $38,308	$38,309 - $56,895	$57,274 - $75,860	$76,239 - $94,825	$95,204 - $113,790	$113,790 +
+1	$3,180	$4,770	$6,360	$7,950	$9,540	$9,540

Note: For families with more than ten (10) members, add for EACH additional family member the amount indicated in the "+1" row under the appropriate poverty level.

RYAN WHITE TITLE I

COST AND ELIGIBILITY SUMMARY
FY 2004-05 (YEAR 14)

(For services included in RFP No. RW1401 only)

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Miami-Dade County
Office of Strategic Business Management

Effective March 1, 2004

RFP No. RW1401
ATTACHMENT 19

RYAN WHITE TITLE I COST AND ELIGIBILITY SUMMARY – FY 2004-05 (YEAR 14) RFP NO. RW1401

IMPORTANT: To be eligible for Ryan White Title I services, the client must be a permanent resident of Miami-Dade County

SERVICE CATEGORY	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM% OF FED. POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Outpatient Medical Care [including Minority AIDS Initiative ("MAI") program]	Client Visit and Unduplicated # of Clients Served	Multiplier applied to reimbursable procedure rate listed in the 2004 Medicare Part B Fee Schedule (Participating, Locality 04) for Evaluation and Management (E&M) codes for outpatient medical care and psychiatric visits only. All other non-E/M procedures will be reimbursed at the 2004 Medicare rate. No multiplier will be applied to non-E&M procedures. Laboratory procedures will be reimbursed at rates included in the Medicare Clinical Laboratory Fee Schedule, dated December 10, 2003. No multiplier may be applied to these laboratory fees.	Maximum Multiplier Rate of 1.50 Applied to Medicare Reimbursable Rates for Evaluation and Management codes for outpatient medical care and psychiatric visits only. All other non-E/M procedures will be reimbursed at the 2004 Medicare rate. No multiplier will be applied to non-E&M procedures.	300%	I, II, III Referral from a primary care physician is required for outpatient specialty care, except for psychiatric services which may be requested by a mental health care professional	Y

*LEGEND: I = HIV+ Asymptomatic, II = HIV+ Symptomatic, III = AIDS (As Defined by the CDC)

RYAN WHITE TITLE I COST AND ELIGIBILITY SUMMARY – FY 2004-05 (YEAR 14) RFP NO. RW1401

IMPORTANT: To be eligible for Ryan White Title I services, the client must be a permanent resident of Miami-Dade County

SERVICE CATEGORY	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM% OF FED. POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Prescription Drugs	Individual Drugs Dispensed, # of Prescriptions Filled, $ Spent per Drug, and Unduplicated # of Clients Served	PHS of Injectable/ Non-Injectable Medication Plus Flat Rate Dispensing Fee AND AWP of Injectable/ Non-Injectable Medication Minus Discount Rate	PHS Price Plus Flat Rate Dispensing Fee AND AWP Minus Applied Discount Rate of No Less Than 7%	300%	I, II, III and Physician's Referral or Prescription, with Letter of Medical Necessity or Prior Authorization Form, if Applicable	Y
Prescription Drugs: Durable Medical Equipment and Supplies (for Administering Prescribed Medications only)	Number of Patients Served, Consumable Medical Supplies and Durable Medical Equipment Distributions per Patient (for Administering Prescribed Medications Only), and Dollar Amount Spent per Patient	Multiplier applied to allowable supply and equipment rate listed in the 2004 Medicare Part B Fee Schedule (Participating, Loc. 04) If no Medicare Rate is available, providers will be reimbursed at the DME Medicaid Handbook Rate, effective March 2003. If no Medicare or Medicaid rate is available, providers must submit a request for a Supplementary Reimbursement Rate. No Multiplier may be applied.	Medicare: Maximum Multiplier Rate of 1.10 Medicaid: Maximum Multiplier Rate of 1.50	300%	I, II, III and Physician's Referral or Prescription, with Letter of Medical Necessity, if Applicable	Y

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*LEGEND: I = HIV+ Asymptomatic, II = HIV+ Symptomatic, III = AIDS (As Defined by the CDC)

RYAN WHITE TITLE I COST AND ELIGIBILITY SUMMARY – FY 2004-05 (YEAR 14) RFP NO. RW1401

IMPORTANT: To be eligible for Ryan White Title I services, the client must be a permanent resident of Miami-Dade County

SERVICE CATEGORY	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM% OF FED. POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Case Management (including "MAI" program)	Type of 15 Minute Encounter (Face-to-Face or Other) and Unduplicated # of Clients Served	Cost of 15 Minute Encounter	$12.50 / Encounter	300%	I, II, III	Y
Case Management: Peer Education and Support Network (PESN) (including "MAI" program)	Type of 15 Minute Encounter (Face-to-Face or Other) and Unduplicated # of Clients Served	Cost of 15 Minute Encounter	$6.25 / Encounter	300%	I, II, III	Y

*LEGEND: I = HIV+ Asymptomatic, II = HIV+ Symptomatic, III = AIDS (As Defined by the CDC)

RYAN WHITE TITLE I COST AND ELIGIBILITY SUMMARY – FY 2004-05 (YEAR 14) RFP NO. RW1401

IMPORTANT: To be eligible for Ryan White Title I services, the client must be a permanent resident of Miami-Dade County

SERVICE CATEGORY	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM% OF FED. POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Substance Abuse Counseling – Residential	# of Days per Client and Unduplicated # of Clients Served	Cost of One Day of Residential Counseling Treatment Per Client	$100.00 per Day [includes the cost of family member(s) participating in the substance abuse counseling session provided during day of treatment]	300%	I, II, III	Y
Outreach Services (including "MAI" program)	Type of 15 Minute Outreach Encounter [Face-to-Face or Other (i.e., Telephone Contact, Referral Activity, etc.)] and Unduplicated # of Clients Served	Line Item Budget	Reimbursement will be based on documents invoices from outreach service providers. Outreach services will be paid based on full-time employees (FTEs) at a salary to be negotiated between the provider and the County. Reimbursement will be based on productivity hours, locales used, clients contacted, risk factors, # of clients connected to care (i.e., medical care, case management, substance abuse treatment, etc.).	N/A	I, II, III	Y

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*LEGEND: I = HIV+ Asymptomatic, II = HIV+ Symptomatic, III = AIDS (As Defined by the CDC)

RYAN WHITE TITLE I COST AND ELIGIBILITY SUMMARY – FY 2004-05 (YEAR 14) RFP NO. RW1401

IMPORTANT: To be eligible for Ryan White Title I services, the client must be a permanent resident of Miami-Dade County

SERVICE CATEGORY	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM% OF FED. POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
AIDS Insurance Continuation Program	Dollars per Insurance Premium, Unduplicated # of Clients Served, and Dollars Expended per Client	Dollars Expended per Insurance Premium Per Client Plus a Dispensing Rate of $15 per month	Reimbursement will be based on documentation of dollars expended per insurance premium plus a dispensing rate. Maximum amount of assistance a client may receive on a monthly basis in $500.	300% Liquid Assets (cash) $4,500; or $5,500 if married or a recognized couple Health Insurance under a group, individual, or COBRA policy	I, II, III	Client must have insurance under a group, individual or COBRA policy. Client must be willing to sign all required forms and to provide eligibility information. A complete financial assessment and disclosure are required.
Insurance Deductibles	Dollars per Deductible, Unduplicated # of Clients Served, and Dollars Expended per Client	Dollars Expended per Client per Deductible Plus a Dispensing Rate	Reimbursement will be based on documentation of dollars expended per deductible plus a dispensing rate. Maximum amount of assistance a client may receive on an annual basis is $2,500.	300%	I, II, III	Y A complete financial assessment and disclosure are required.

*LEGEND: I = HIV+ Asymptomatic, II = HIV+ Symptomatic, III = AIDS (As Defined by the CDC)

RYAN WHITE TITLE I COST AND ELIGIBILITY SUMMARY – FY 2004-05 (YEAR 14) RFP NO. RW1401
IMPORTANT: To be eligible for Ryan White Title I services, the client must be a permanent resident of Miami-Dade County

SERVICE CATEGORY	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM% OF FED. POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Prescription Drugs Co-payments	Dollars per Co-payment, Unduplicated # of Clients Served, and Dollars per Client	Dollars Expended per Co-payment Plus a Dispensing Rate	Reimbursement will be based on documentation of dollars expended per co-payment plus a dispensing rate. Assistance is restricted to those medications listed on the current approved Ryan White Title I Prescription Drugs Formulary	300%	I, II, III Physician's Prescription	Y A complete financial assessment and disclosure are required.

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*LEGEND: I = HIV+ Asymptomatic, II = HIV+ Symptomatic, III = AIDS (As Defined by the CDC)

RFP No. RW1401
ATTACHMENT 20

PRICE FORM

Instructions for completing the Outpatient Medical Care Price Form are provided on the reverse side of this document.

OUTPATIENT MEDICAL CARE

Organization	# of Unduplicated Clients to be Served

Reimbursement Rate

2004 Medicare Part B (Loc. 04/Participating) Reimbursable Rate* (Provider negotiated rates will not be accepted)	X	Multiplier Rate*	Total Request

Signature	Name (Print or Type)	Title

Corporate Seal

Sworn to and subscribed before me
this day of , 2004.

OR

NOTARY PUBLIC, State of Florida
at Large

**NOTE - Reimbursements for this service will be based on the 2004 Medicare Part B (Loc. 04/Participating) Reimbursable Rate for the medical procedure(s) provided to the client, times the multiplier rate proposed on this price form. The multiplier rate may not exceed 1.50 for Evaluation and Management Codes for outpatient medical care and psychiatric visits only. All other non-Evaluation and Management procedures will be reimbursed at the 2004 Medicare Rate. No multiplier rate will be applied to non-Evaluation and Management procedures.*

Instructions for Completing
Outpatient Medical Care Price Form

1. In the box titled *"Organization,"* please type the full legal name of the proposing organization.

2. In the box titled *"# of Unduplicated Clients to be Served,"* please type the estimated number of eligible clients (counting each client only once) that will be provided outpatient medical care services if the proposing organization is awarded the full amount of its request.

3. In the box titled *"Multiplier Rate,"* please type the proposing organization's that will be utilized to cover the cost incurred in the delivery of outpatient medical care services if the proposing organization is awarded the full amount of its request. **This multiplier rate may not exceed 1.50 for Evaluation and Management codes for outpatient medical care and psychiatric visits only. All other non-Evaluation and Management procedures will be reimbursed at the 2004 Medicare Rate. No multiplier rate will be applied to non-Evaluation and Management procedures.**

4. In the box titled *"Total Request,"* please type the total dollar amount that the proposing organization is requesting for outpatient medical care services.

5. In the box titled *"Signature,"* please have an officer of the proposing organization, who is legally authorized to enter into a contractual relationship in the name of the proposing organization, sign this Price Form.

6. In the box titled *"Name,"* please print legibly or type the name of the officer whose signature appears in the "Signature" box of this Price Form.

7. In the box labeled *"Title,"* please type the signing officer's title or position in the proposing organization.

NOTE: **Either instruction number 8 or 9 must be followed in order for this document to be deemed adequate and thus considered for possible contract award.**

8. In the box titled *"Corporate Seal,"* please affix the proposing organization's corporate seal, if available.

9. If a corporate seal is not available, please have this Price Form notarized in the box provided under the statement *"Sworn to and subscribed before me this __ day of __, 2004".*

NOTE: **Proposing organizations are reminded that a categorical (line item) budget, including a narrative justification and a detailed description of how unit cost(s) were calculated, MUST be submitted with this Price Form. Failure to submit this information will disqualify the organization's proposal from further consideration.**

RFP No. RW1401
ATTACHMENT 20a

PRICE FORM

Instructions for completing the Minority AIDS Initiative (MAI) Outpatient Medical Care Price Form are provided on the reverse side of this document.

MAI OUTPATIENT MEDICAL CARE (TARGETING MINORITY POPULATIONS)

Organization	# of Unduplicated Clients to be served

Please specify the percentage of unduplicated clients in each target minority population to be served (must add to 100%)	
Black/African American *(including Haitian Community)*	____%
Hispanic	____%
Native American	____%
Other (Specify _____)	____%
Total	**100%**

Reimbursement Rate

2004 Medicare Part B (Loc 04/Participating) Reimbursable Rate* (Provider negotiated rates will not be accepted)	X	Multiplier Rate*

Total Request

Signature	Name (Print or Type)	Title

Corporate Seal

Sworn to and subscribed before me
this day of , 2004.

OR

NOTARY PUBLIC, State of Florida
at Large

**NOTE - Reimbursements for this service will be based on the 2004 Medicare Part B (Loc. 04/Participating) Reimbursable Rate for the medical procedure(s) provided to the client, times the multiplier rate proposed on this price form. The multiplier rate may not exceed 1.50 for Evaluation and Management Codes for outpatient medical care and psychiatric visits only. All other non-Evaluation and Management procedures will be reimbursed at the 2004 Medicare Rate. No multiplier rate will be applied to non-Evaluation and Management procedures.*

Instructions for Completing
Minority AIDS Initiative (MAI) Outpatient Medical Care
Price Form

1. In the box titled *"Organization,"* please type the full legal name of the proposing organization.

2. In the box titled *"# of Unduplicated Clients to be Served,"* please type the estimated number of eligible clients (counting each client only once) that will be provided MAI outpatient medical care services if the proposing organization is awarded the full amount of its request.

3. In the box titled *"Please specify the percentage of unduplicated clients in each target minority population to be served,"* please type the estimated percentage of Black/African Americans (including Haitian Community), Hispanic, Native American or other minorities that will be provided MAI outpatient medical care services. All the percentages must add to 100.

4. In the box titled *"Multiplier Rate,"* please type the proposing organization's rate that will be utilized to cover the cost incurred in the delivery of MAI outpatient medical care services if the proposing organization is awarded the full amount of its request. **This multiplier rate may not exceed 1.50 for Evaluation and Management codes for outpatient medical care and psychiatric visits only. All other non-Evaluation and Management procedures will be reimbursed at the 2004 Medicare Rate. No multiplier rate will be applied to non-Evaluation and Management Procedures.**

5. In the box titled *"Total Request,"* please type the total dollar amount that the proposing organization is requesting for MAI outpatient medical care services.

6. In the box titled *"Signature,"* please have an officer of the proposing organization, who is legally authorized to enter into a contractual relationship in the name of the proposing organization, sign this Price Form.

7. In the box titled *"Name,"* please print legibly or type the name of the officer whose signature appears in the "Signature" box of this Price Form.

8. In the box labeled *"Title,"* please type the signing officer's title or position in the proposing organization.

NOTE: **Either instruction number 9 or 10 must be followed in order for this document to be deemed adequate and thus considered for possible contract award.**

9. In the box titled *"Corporate Seal,"* please affix the proposing organization's corporate seal, if available.

10. If a corporate seal is not available, please have this Price Form notarized in the box provided under the statement *"Sworn to and subscribed before me this __ day of __, 2004".*

NOTE: **Proposing organizations are reminded that a categorical (line item) budget, including a narrative justification and a detailed description of how unit cost(s) were calculated, MUST be submitted with this Price Form. Failure to submit this information will disqualify the organization's proposal from further consideration.**

RFP No. RW1401
ATTACHMENT 21

PRICE FORM

Instructions for completing the Prescription Drugs (AWP) Price Form are provided on the reverse side of this document.

PRESCRIPTION DRUGS (AWP)

Organization	# of Unduplicated Clients to be Served

Reimbursement Rate

Average Wholesale Price (AWP)	–	Discount Rate (%)*	Total Request
		_____% (In the blank line provided, indicate the proposed discount rate applied to the AWP)	

Signature	Name (Print or Type)	Title

Corporate Seal	OR	Sworn to and subscribed before me this day of , 2004.
		NOTARY PUBLIC, State of Florida at Large

*NOTE - ***Reimbursement for this service will be based on the Average Wholesale Price (AWP) of the prescription(s) provided to a Ryan White Title I patient, minus a per-prescription discount rate. The discount rate may not be less than 7%. Providers may utilize a discount rate higher than 7% (i.e., AWP minus 10%). A current copy of the Average Wholesale Price List containing the prescription drugs that will be available under this agreement MUST be submitted along with this price form. These medications must be included in the most recent version of the Ryan White Title I Prescription Drugs Formulary.***

Instructions for Completing
Prescription Drugs (AWP) Price Form

1. In the box titled *"Organization,"* please type the full legal name of the proposing organization.

2. In the box titled *"# of Unduplicated Clients to be Served,"* please type the estimated number of eligible clients (counting each client only once) that will be provided prescription drugs services if the proposing organization is awarded the full amount of its request.

3. In the box titled *"Discount Rate,"* please type the proposing organization's per-prescription discount rate to be applied to the Average Wholesale Price (AWP). The total cost of each prescription should include the cost of home delivery, if provided.

NOTE: **Reimbursement for this service will be based on the Average Wholesale Price (AWP) of the prescription(s) provided to a Ryan White Title I patient, minus a per-prescription discount rate. The discount rate may not be less than 7%. Providers may utilize a discount rate higher than 7% (i.e. AWP minus 10%). A current copy of the Average Wholesale Price List containing the prescription drugs that will be available under this agreement MUST be submitted along with this price form. These medications must be included in the most recent version of the Ryan White Title I Prescription Drugs Formulary.**

4. In the box titled *"Total Request,"* please type the total dollar amount that the proposing organization is requesting for prescription drugs services.

5. In the box titled *"Signature,"* please have an officer of the proposing organization, who is legally authorized to enter into a contractual relationship in the name of the proposing organization, sign this Price Form.

6. In the box titled *"Name,"* please print legibly or type the name of the officer whose signature appears in the "Signature" box of this Price Form.

7. In the box labeled *"Title,"* please type the signing officer's title or position in the proposing organization.

NOTE: **Either instruction number 8 or 9 must be followed in order for this document to be deemed adequate and thus considered for possible contract award.**

8. In the box titled *"Corporate Seal,"* please affix the proposing organization's corporate seal, if available.

9. If a corporate seal is not available, please have this Price Form notarized in the box provided under the statement *"Sworn to and subscribed before me this __ day of __, 2004".*

NOTE: **Proposing organizations are reminded that a categorical (line item) budget, including a narrative justification and a detailed description of how unit cost(s) were calculated, MUST be submitted with this Price Form. Failure to submit this information will disqualify the organization's proposal from further consideration.**

RFP No. RW1401
ATTACHMENT 21a

PRICE FORM

Instructions for completing the Prescription Drugs (PHS) Price Form are provided on the reverse side of this document.

PRESCRIPTION DRUGS (PHS)

Organization	# of Unduplicated Clients to be Served

Reimbursement Rate

Public Health Service (PHS) Price	+	Flat Fee	Total Request
		_____	

Signature	Name (Print or Type)	Title

Corporate Seal

OR

Sworn to and subscribed before me
this day of , 2004.

NOTARY PUBLIC, State of Florida
at Large

*NOTE - ***Reimbursement for this service will be based on the Public Health Service (PHS) price of the prescription(s) provided to a Ryan White Title I patient, plus a flat fee per prescription. These medications must be included in the most recent version of the Ryan White Title I Prescription Drugs Formulary.***

Instructions for Completing
Prescription Drugs (PHS Pricing) Price Form

1. In the box titled *"Organization,"* please type the full legal name of the proposing organization.

2. In the box titled *"# of Unduplicated Clients to be Served,"* please type the estimated number of eligible clients (counting each client only once) that will be provided with prescription drugs services if the proposing organization is awarded the full amount of its request.

3. In the box titled *"Flat Fee,"* please type the proposing organization's per-prescription dispensing flat rate to be applied to the Public Health Service (PHS) price. Total costs should include the cost of home delivery and other direct costs associated with the provision of this service.

NOTE: **Reimbursement for this service will be based on the Public Health Service (PHS) price of the prescription(s) provided to a Ryan White Title I patient, plus a flat fee. These medications must be included in the most recent version of the Ryan White Title I Prescription Drugs Formulary.**

4. In the box titled *"Total Request,"* please type the total dollar amount that the proposing organization is requesting for prescription drugs services.

5. In the box titled *"Signature,"* please have an officer of the proposing organization, who is legally authorized to enter into a contractual relationship in the name of the proposing organization, sign this Price Form.

6. In the box titled *"Name,"* please print legibly or type the name of the officer whose signature appears in the "Signature" box of this Price Form.

7. In the box labeled *"Title,"* please type the signing officer's title or position in the proposing organization.

NOTE: **Either instruction number 8 or 9 must be followed in order for this document to be deemed adequate and thus considered for possible contract award.**

8. In the box titled *"Corporate Seal,"* please affix the proposing organization's corporate seal, if available.

9. If a corporate seal is not available, please have this Price Form notarized in the box provided under the statement *"Sworn to and subscribed before me this __ day of __, 2004".*

NOTE: **Proposing organizations are reminded that a categorical (line item) budget, including a narrative justification and a detailed description of how unit cost(s) were calculated, MUST be submitted with this Price Form. Failure to submit this information will disqualify the organization's proposal from further consideration.**

RFP No. RW1401
ATTACHMENT 21b

MIAMI-DADE COUNTY, FLORIDA

OFFICE OF STRATEGIC BUSINESS MANAGEMENT
RYAN WHITE TITLE I PROGRAM
140 WEST FLAGLER STREET
ROOM 1604
MIAMI, FLORIDA 33130-1563
(305) 375-4742
FAX (305) 375-4454

February 9, 2004

Dear Ryan White Title I Service Provider:

Enclosed for your information and distribution is a revised Ryan White Title I Prescription Drugs Formulary with an effective date of February 9, 2004. At the recommendation of the Miami-Dade HIV/AIDS Partnership, the following medication has been added to the Formulary:

Section II - Antiretrovirals (Protease Inhibitors)

Generic	**Trade/Brand Name**
Fosamprenavir Calcium♦	Lexiva♦

♦Effective February 9, 2004, Title I funds may only be used to reimburse for this medication when funding is unavailable through the State of Florida AIDS Drug Assistance Program (ADAP).

In addition to the change indicated above, effective February 9, 2004, the following new drug combination product is being added to the Formulary:

Section IV - Other (Diabetic Medications)

Generic	**Trade/Brand Name**
Glyburide/Metformin*	Glucovance

* It is important to note that this medication is not a new addition to the Title I Prescription Drugs Formulary, but rather a new drug combination that will be covered by the Title I program.

IMPORTANT: The Ryan White Title I Prescription Drugs Formulary is revised periodically by the Miami-Dade HIV/AIDS Partnership. It is imperative that all revisions to the Formulary be carefully reviewed and understood by direct service staff and recipients of Title I funded medications. Please notify program staff and clients immediately of these revisions. If further clarification is needed on the enclosed material, please contact Theresa Wright-Williams, or myself, at (305) 375-4742.

Sincerely,

Yocasta Juliao
Project Director

Enclosure

RYAN WHITE TITLE I PRESCRIPTION DRUGS FORMULARY

This is a comprehensive list of medications that may be required by individuals with HIV Spectrum Disease. Some medications are listed more than once as they may be indicated for different conditions. The formulary was organized in this manner to encourage practitioners to use medications appropriately. **All items will be reimbursed in their generic equivalent. Reimbursement for name brand items will only be permitted in the event that a generic equivalent is not available on the market.** There may be special situations where medications are needed that are not on this list (i.e., HIV-related heart disease or HIV-related kidney failure) and a mechanism should be set up to deal with such extenuating circumstances. Medications available through the federal AIDS Drug Assistance Program **(ADAP)** via the Miami-Dade County Health Department are identified with a symbol (♦). These drugs are available to clients fulfilling the ADAP eligibility requirements.

I. PROPHYLACTIC MEDICATIONS

	Generic Name	Trade Name (for reference only)
PCP	Pentamidine for inhalation	Pentam, Nebupent
MAC	Clarithromycin♦	Biaxin
	Azithromycin♦	Zithromax
	Rifabutin♦	Mycobutin
	Pneumococcal Vaccine ♦	Pneumovax
Fungal	Ketoconazole	Nizoral
	Amphotericin B (Oral)	Fungizone
	Fluconazole♦	Diflucan
	Terconazole♦	Terazol
	Miconazole Topical♦	Miconazole Nitrate 2%
	Itraconazole▪	Sporanox 100mg (Capsules)
Nutritional	Multivitamins with minerals	Prenatal Vitamins
	Potassium (Oral)	
	Antioxidant formula	
	Boost Liquid*	
	Progain Powder◊	
	Berocca Plus	
	Pyridoxine	Vitamin B6
	Resource Just for Kids*	
	Not Available□	IgG Pure◊
Hepatitis	Hepatitis A Vaccine ♦	Havrix Adult
	Hepatitis B Vaccine ♦	Engerix B Adult

▪ **NOTE: In order for a patient to obtain this medication through the Title I program, one of the two conditions (histoplasmosis or aspergillosis) must have been identified and documented in the client's chart by his/her physician. In addition, the Ryan White Sporanox Letter of Medical Necessity is required. Title I funds may only be used to cover one of the two conditions.**

* **NOTE: The Ryan White Nutritional Supplements Letter of Medical Necessity is required. Title I funds may only be used to reimburse for nutritional supplements for the treatment of indications experienced by HIV+ children 18 years and under (for Boost Liquid) and HIV+ children 1-10 years of age (for Resource Just for Kids). These nutritional supplements are only available in liquid form.**

◊ **NOTE: These nutritional supplements are available in powder form only and require a referral from both a physician and a nutritionist.**

□ **NOTE: There is no generic equivalent for this new brand name product.**

II. ANTIRETROVIRALS

Title I funds may be used to reimburse for antiretrovirals (on a month-to-month basis) only when these medications are unavailable through ADAP.

	Generic Name	Trade Name (for reference only)
Nucleoside Reverse Transcriptase Inhibitors	Zidovudine	Retrovir (AZT)♦
	Didanosine (ddI)♦	Videx
	Zalcitabine (ddC)♦	Hivid
	Stavudine (d4T) ♦	Zerit
	Lamivudine (3TC) ♦	Epivir
	Zidovudine/lamivudine ♦	Combivir
	Abacavir (1592) ♦	Ziagen
	Hydroxyurea (HV) ♦	Hydrea
	Abacavir Sulfate/ Lamivudine/Zidovudine (Tablets) 150 mg/300mg♦	Trizivir♦
	Didanosine (ddI) 400 mg♦	Videx EC (Capsules)♦
	Tenofovir (300 mg tablet)♦	Viread♦
	Emtricitabine♦	Emtriva♦
Protease Inhibitors*	Indinavir♦	Crixivan
	Ritonavir♦	Norvir
	Saquinavir♦	Invirase, Fortovase
	Nelfinavir♦	Viracept
	Amprenavir ♦	Agenerase
	Lopinavir/Ritonavir (Capsules & Oral Solution)♦	Kaletra ♦
	Atazanavir♦	

		Reyataz♦
	Generic Name	**Trade Name (for reference only)**
	Fosamprenavir Calcium♦	Lexiva
Non-Nucleoside Reverse Transcriptase Inhibitors	Delavirdine♦	Rescriptor
	Nevirapine♦	Viramune
	Efavirenz♦	Sustiva
	Efavirenz♦	Sustiva 600mg

* **NOTE: Effective January 1, 1998 Title I funds may be used to reimburse for Protease Inhibitors and Non-Nucleocide Reverse Transcriptase Inhibitors (on a month-to-month basis) only when these medications are unavailable through ADAP.**

III. TREATMENT OF INFECTIONS/CONDITIONS

Candida	Lidocaine (viscous)	Xylocaine
	Nystatin suspension	Mycostatin/Nilstat
	Clotrimazole (troches & cream)	Mycelex
	Ketoconazole	Nizoral
	Itraconazole ♦	Sporanox (Oral)
Crypotosparidium L Belli	Paromomycin	Humatin
	Metronidazole	Flagyl
CMV	Ganciclovir (for IV infusion)	
	Ganciclovir (oral)	Cytovene
	Foscarnet (for IV infusion)	
	Valganciclovir	Valcyte
	Valacyclovir 500mg/1000mg (tablets)▪	Valtrex

▪ **NOTE: In order for a patient to obtain this medication through the Title I program, one of the following conditions must have been identified and documented in the patient's chart by his/her physician: (1) patient has acute Herpes Zoster, and requires Valacyclovir 1000mg three (3) times daily; or, (2) patient requires Valacyclovir daily suppressive therapy for recurrent Herpes Simplex episodes occurring while receiving standard doses of daily suppressive Acyclovir therapy. To qualify for daily suppressive Valacyclovir therapy, the patient must have had <u>more than one</u> Herpes recurrence while receiving daily Acyclovir suppressive therapy. This must be documented by attaching a photocopy of a recent Acyclovir prescription to the Letter of Medical Necessity submitted with the <u>first</u> prescription for Valacyclovir tablets. This is not required on subsequent refills. Title I**

funds may only be used to pay for this medication if one the patient is suffering from one of the two conditions specified above.

	Generic Name	Trade Name (for reference only)
Dermatitis (seborrheic and other)	Hydrocortisone Topical (cream & ointment)	Hytone
	Triamcinolone (cream & ointment)	Kenalog
	Neomycin/polymixin/zin	Bacitracin
	Aquaphor (generic)	
	Betamethason	Valisone
	Capsaicin	Zostrix
	Clobetasol ointment	Temovate
	Fluocimonide	Lidex
	Flurouracil	Effudex
	Permethrin	Elimite
	Podofilox	Condylox
	Sarna lotion	
	Imiquimod 5%	Aldara Cream
	Erythromycin Topical Solution	A/T/S Solution
	Benzoyl Peroxide Topical (5%-10% ointment)	Benzamycin
	Fluocinolone (gel & ointment)	
	Doxepin	Sinequan
Herpes	Silver Sulfadiazine	Silvadene
	Acyclovir♦	Zovirax
Influenza A/B	Oseltamivir	Tamiflu
Mycobacterium Avium (MAC)	Clarithromycin♦	Biaxin
	Ethambutol ♦	Myambutol
	Azithromycin ♦	Zithromax
	Rifabutin♦	Mycobutin
	Pneumococcal Vaccine ♦	Pneumovax
Tuberculosis	Rifampin	Rifadin, Rimactane
	Isoniazid (INH)	Laniazid, Nydrazid
	Pyrazinamide	PZA
	Ethambutol♦	Myambutol

	Dapsone (DDS) ♦	Avlosulfon

	Generic Name	Trade Name (for reference only)
PCP	Trimethoprim/ Sulfamethoxazole ♦	Septra/Bactrim
	Clindamycin	Cleocin
	Primaquine	
	Atovaquone ♦	Mepron
	Trimetrexate	
	Prednisone	
Syphilis	Penicillin (VK, benzathine, aqueous)	
	Amoxicillin	
	Amoxicillin / Clavulinic acid	Augmentin
	Probenecid	Benemid
Thrombocytopenia	Danazol	
	Prednisone	
Toxoplasmosis	Sulfadiazine	
	Pyrimethamine ♦	Daraprim
	Clindamycin	Cleocin
	Leucovorin* ♦	Folinic acid*

* **NOTE: Title I funds may only be used to reimburse for this medication for the treatment of Toxoplasmosis, and must be written as such on the prescription.**

Diarrhea	Erythromycin	
	Ofloxacin	Floxin
	Diphenoxylate ♦	Lomotil
	Loperamide	Imodium
	Tincture of opium	
Wasting/ Weight loss	Cyproheptadine	Periactin
	Dronabinol **(1 b.i.d dosage, 2.5 mg)***	Marinol*
	Megestrol* ♦	Megace Suspension*
	Pancrelipase*	Ultrase*
	Oxandrolone ** ♦	Oxandrin **

Anabolic Agents	Testosterone (Injection)▪ ♦	Testosterone Enanthate▪ or Cypionate
	Testosterone Gel*** **Generic Name**	Androgel 1% **Trade Name** **(for reference only)**
	Nandrolone** ♦	Deca Durabolin **
	Oxymetholone **	Anadrol-50 **
Neuropathy/ Anti-Convulsants	Phenytoin (Dilantin)	Dilantin
	Carbamazepine (Tegretol)	Tegretol
	Amitriptyline ♦	Elavil
	Imipramine	Tofranil
	Desipramine	Norpramin
	Valproate	Depakote
	Gabapentin ♦	Neurontin
	Lamotrigine ♦	Lamictal
	Nortriptyline	Pamelor
Lymphoma	Procarbazine	Matulane

* **NOTE: The Ryan White Appetite Stimulant Letter of Medical Necessity is required, and the need for this medication must be reassessed monthly. Title I funds may only be used to cover one (1) b.i.d. dosage, 2.5 m.g. of Dronabinol (Marinol).**

▪ **NOTE: To qualify for Title I coverage, the patient's testosterone level must be below a normal reading. Prescribing physicians must include the patient's most recent testosterone level on the prescription for this medication. If this information is not provided on the prescription, Title I will not cover the cost of this medication.**

** **In order for a patient to obtain this medication through the Title I program, one of the following conditions must have been identified and documented in the client's chart by his/her physician:**

1. **The patient is experiencing involuntary weight loss of 3% in 1 month, 5% in 6 months, or 10% in 12 months.**

or

2. **If the patient's baseline weight is not available, then the patient will qualify for Title I assistance if his/her Body Mass Index (BMI) is less than 80% of a normal reading.**

*** **To qualify for Title I coverage, the patient must experience a low serum testosterone level as defined by the current medical guidelines of the Florida Department of Health and Human Services (a testosterone level below normal as measured by the reference lab.) Prescribing physicians must include the patient's most recent testosterone level on the Letter of Medical Necessity for Testosterone Gel (Androgel ® 1%). If this information is not provided, Title I will not cover the cost of this medication. In**

addition, the Ryan White Letter of Medical Necessity is required at the time of initial referral explaining the contraindication, and MUST be submitted with a dated lab report showing the testosterone level results.

IV. OTHER

	Generic Name	Trade Name (for reference only)
Antibiotics	Cephalexin	Keflex
	Penicillin (VK, benzathine, aqueous)	
	Amoxicillin / Clavulinic acid	Augmentin
	Ciprofloxacin	Cipro
	Lomefloxacin	Maxaquin
	Doxycycline	Vibra-Tab
	Tetracycline	
	Ofloxacin	Floxin
	Levofloxacin	Levaquin
Pain Medications	Naproxen	Naprosyn
	Ibuprofen	Advil, Motrin
	Acetaminophen	Tylenol
	Codeine	
	Morphine (oral, duramorph only)	
	Oxycodone	Roxycodone
	Morphine	MS Contin
	Aspirin EC	Aspirin EC
	Oxycodone / Acetaminophen 5/325mg (generic only)	Percocet 5/325mg
Cardiac / Hypertension Drugs	Verapamil	Calan
	Quinidine	Quinaglute
	Digoxin	Lanoxin
	Benazepril	Lotensin
	Furosemide	Lasix
	Hydrochlorthiazide	Hydrodiuril
	Atenolol	Tenormin
	Metoprolol	Lopressor
	Enalapril	Vasotec
	Captopril	Capoten
	Diltiazem CD	Cardizem CD
	Nifedipine XL	Adalat CC or Procardia XL
	Eprosartan (400mg & 600mg)•	Teveten
	Warfarin	Coumadin
	Nitroglycerin	Nitrotab/Nitro-stat SL tabs, Nitrolingual pump spray, Nitroglycerin caps, Nitro-Dur patches, Nitro-Bid

		ointment
Anti-emetics (vomiting)	Prochlorperazine ♦ Metoclopramide	Compazine Reglan
Psychiatric Medications	**Generic Name**	**Trade Name (for reference only)**
	Valproate Gabapentin	Depakote Neutrontin
	Atypical Antipsychotic	
	Olanzapine Risperidone Quetiapine	Zyprexa Risperdal Seroquel
	Anxiolytic	
	Lorazepam Clonazepam	Ativan Klonopin
	Antidepressants	
	Mirtazapine Sertraline Lithium Paroxetine Bupropion Citalopram Venlafaxine	Remeron Zoloft Eskalith Paxil Wellbutrin Celexa Effexor
Anti-ulcer	Antacids Multi-vitamins Pantoprazole◊ Ranitidine (75mg)	Mylanta, Maalox Protonix Zantac (75mg)
Nutritional	Multi-vitamins Anti-oxidants Iron Vitamin B-12 (Injection only) Potassium (Oral)	 Feosol Cyanocobalamin
	B-Complex Multivitamins Lactase Enzyme (Oral) Lactobacillus Acidophilus (Granules)	Berocca & Berocca Plus Lactaid Lactinex
Sleeping aids	Temazepam	Restoril

(Hypnotic)	Diphenhydramine	Benadryl
	Hydroxyzine (HCI & Pamoate)	Vistaril, Atarax
	Doxepin	Sinequan
	Trazondone	Desyrel
	Generic Name	**Trade Name (for reference only)**
Anti-histamines	Diphenhydramine	Benadryl
	Hydroxyzine (HCI & Pamoate)	Vistaril, Atarax
Cough Medications	Guaifenesin with codeine liquid	Robitussin
	Guaifenesin with dextromethorphan (without alcohol)	
	Guaifenesin with pseudoephedrine	
	Pseudoephedrine	Sudafed
Bronchodilators / Asthma	Albuterol	Proventil
	Beclomethoasone	QVAR (40mg&80mg)
	Fluticasone	Flonase
	Triamcinolone	Azmacort
	Theophylline Slow Release	Theodur, Theo-24
	Inhaler spacer (one time only)	Inhaler spacer
Ophthalmic / Otic Preparation	Sulfacetamide eye drops	Sulamyd
	Tobramycin eye drops	Tobrex
	Hydrocortisone/neomycin drops for ears	
	Gentamicin Ophthalmic (Solution & Ointment)	Garamycin
	Prednisolone-Acetate Ophthalmic	Pred Forte
	Homatropine Ophthalmic	Isopto Homatropine
	Brimonidine	Alphagan
	Acetazolamide	Diamox
	Timolol	Timoptic
	Dorzolamide	Trusopt
	Latanoprost	Xalatan
	Ofloxacin□	Ocuflox
Diabetic Medications	Glipizide ♦	Glucotrol
	Glyburide ♦	Micronase
	Metformin ♦	Glucophage
	Insulin*	Humulin, Novolin* (R, N, 70/30)

	Glyburide/Metformin	Glucovance
Cholesterol Reducing Drugs	Gemfibrozil ♦ Atorvastatin ♦ Pravastatin ♦ Niacin	LOPID Lipitor Pravachol Niaspan
	Generic Name	**Trade Name (for reference only)**
Hematopoietic Agents	Filgrastim ♦ Erythropoietin ♦	Neupogen Epogen, Procrit

NOTES:

* **Title I funds may only be used to reimburse for these medications for the treatment of insulin dependent diabetes mellitus secondary to HIV treatment, and must be written as such on the prescription.**

• In order to receive Eprosartan (Teveten) through the Ryan White Title I program, the patient must have had a prior history of intolerability to the use of Angiotensin Converting Enzyme (ACE) Inhibitors.

◊ The enclosed Ryan White Title I Letter of Medical Necessity for Pantoprazole (Protonix) must be signed by a Board certified gastroenterologist when this medication is indicated for the treatment of Erosive Esophagitis, or Barrett's Esophagus, or to treat a hypersecretory condition. In addition, the gastroenterologist must certify that a proton pump inhibitor is medically necessary.

◊ Indication of Pantoprazole (Protonix) for the treatment of Helicobacter pylori is restricted to a non-refillable ten (10) day supply of twenty (20) tablets to be prescribed no more than twice in a one-year period, in conjunction with the appropriate antibiotics. The prescription must state that this drug is "medically necessary for treatment of Helicobacter Pyroli."

□ Ofloxacin (Ocuflox) is restricted to ophthalmologist use only for the indication of corneal ulceration.

V. MEDICATIONS AVAILABLE SPECIFICALLY FOR CHILDREN*

Famciclovir	Famvir
Cefaclor	Ceclor
Griseofulvin	Gris-peg
Phenobarbital	Phenobarbital

* **NOTE:** **Title I funds may only be used to reimburse for these medications for the treatment of indications experienced by HIV+ children 12 years and under. These medications are only available in liquid or suspension form.**

VI. DENTAL MEDICATIONS

Chlorhexidine Gluconate (0.12%)	Peridex

MIAMI-DADE COUNTY, FLORIDA

MIAMI-DADE

OFFICE OF MANAGEMENT AND BUDGET
RYAN WHITE TITLE I PROGRAM
140 WEST FLAGLER STREET
ROOM 1604
MIAMI, FLORIDA 33130-1563
(305) 375-4742
FAX (305) 375-4454

April 23, 2003

Dear Ryan White Title I Service Provider:

RE: New Policies and Restrictions on Ryan White Title I Prescription Drugs Services

On April 14, 2003 the Miami-Dade HIV/AIDS Partnership approved several service policies and cost containment measures that affect the Ryan White Title I Prescription Drugs service category. These new policies and program restrictions are necessary in order to maximize the use of public and private resources available in the community for pharmaceutical services and conserve limited resources under the Ryan White Title I program for HIV/AIDS related medications. The following program policies and restrictions are effective retroactive to March 1, 2003:

Required Enrollment in Medicaid or the AIDS Drug Assistance Program

- Case management providers are contractually required to immediately seek enrollment in the Medicaid Program for clients who qualify for prescription drugs assistance, particularly children. If not eligible for Medicaid, these individuals should be referred to the Miami-Dade County Health Department AIDS Drug Assistance Program (ADAP) for medications available under the ADAP Formulary. Title I pharmaceutical services should only be accessed after the client has been screened for eligibility and determined not to qualify for any other benefit program. Title I can also be accessed if the medication needed by the client is not available through other public or private sources, and only if the medication appears on the most recent Title I Prescription Drugs Formulary. Children who are denied Medicaid assistance should be immediately referred to a legal assistance service provider to appeal the non-eligibility determination.

- Children currently receiving adult dosages of medications included in the Title I Prescription Drugs Formulary must be immediately transferred to Medicaid, if eligible, or to ADAP if Medicaid eligibility is denied. This process must be completed within 30 days from the effective date mentioned above (no later than May 14, 2003). If this process is not conducted as required, pediatric patients may be subject to possible discontinuation of medications under the Title I Program.

Temporary Suspension of Oxandrin®

- The Title I Program will temporarily suspend coverage of Oxandrin. New prescriptions for this medication and refills for a period of more than three (3) months will not be honored. This suspension will remain in effect until the Partnership decides to reinstate the use of Title I funds to pay for this medication.

Use of Medicaid Guidelines (Forms) for Neupogen® (Filgrastim) and Procrit® (Epoetin alfa)

- Physicians prescribing Neupogen or Procrit to patients needing to access Title I pharmaceutical services are now required to complete Prior Authorization Forms (see Attachment A for Neupogen and Attachment B for Procrit). Both forms were adopted by the Partnership from the Medicaid Program and, with the exception of formatting differences, the information required remains unchanged. These forms must be submitted to the Title I pharmacy along with the original prescription and lab results dated within the last three (3) months for Neupogen and the last two (2) months for Procrit. The information collected by the Title I pharmacy will be monitored and shared in aggregate form with the Partnership's Medical Care Subcommittee for comparison with Medicaid algorithms.

Adoption of ADAP Guidelines for Pending Lab Results

- The following ADAP guidelines have been adopted by the Title I program to establish client eligibility for Title I pharmaceutical services while ADAP eligibility is being determined due to pending medical laboratory results:

A. Patient is a first-time ADAP applicant, NOT currently receiving prescription drugs treatment, with pending labs:

1. Wait for the lab results and then enroll patient in ADAP **(preferred option)**;
2. If the physician insists, then refer the patient for Title I pharmaceutical services since ADAP eligibility has not been established.

B. Patient is a first-time ADAP applicant, currently IN prescription drugs treatment, with pending labs: ***(includes patients recently released from a hospital; individuals who have lost insurance coverage; patients who are no longer eligible for Medicaid assistance due to missed appointments, etc.)***

1. Use lab results from latest source of treatment, ONLY if less than four (4) months old, then enroll patient in ADAP;
2. If lab results are unavailable or greater than four (4) months old, then refer the patient for Title I pharmaceutical services since ADAP eligibility has not been established.

C. Re-enrollments for ADAP, with pending labs if patient has been compliant with monthly pick-up of medications:

1. Use most recent lab results available, even if they are older than six (6) months;
2. Case Manager must make the following note in the ADAP re-enrollment form: ****New labs ordered & date/pending results (indicate date labs were ordered);***
3. New labs must be reported within two (2) weeks;
4. Patient must still pick-up medications at regular ADAP pharmacy
5. **DO NOT** refer patient to the Title I pharmacy.

D. Re-enrollments for ADAP, with pending labs if patient <u>has NOT been</u> compliant with monthly pick-up of medications:

1. Patient who has failed to pick-up his/her monthly supply of medications must be referred to his/her physician for re-evaluation;
2. The ADAP pharmacy will not dispense medications until the patient is re-evaluated by the physician;
3. Once the lab results are available, with the approval of the physician, medications will be dispensed, if the client remains eligible for ADAP assistance;
4. **<u>DO NOT</u>** refer the patient to the Title I pharmacy.

<u>IMPORTANT</u>

These guidelines must be strictly followed by case managers making referrals for Title I prescription drugs services. Failure of Title I providers to abide by these guidelines will result in financial liability to their organization.

<u>Moratorium on the Ryan White Title I Prescription Drugs Formulary</u>

- The Partnership has established a moratorium on the Ryan White Title I Prescription Drugs Formulary that will be in effect until further notice. New medications, not previously on the Formulary, will not be considered unless the request for the addition is due to an emergency situation or life saving circumstances.

All appropriate program staff and clients must be notified immediately of the new service policies and added restrictions to Title I pharmaceutical services. Please contact me at (305) 375-4742 if further clarification is needed on any of the information presented above. Thank you for your cooperation.

Sincerely,

Yocasta Juliao
Project Director

Attachments

c: Carla J. Valle-Schwenk, Program Administrator, Ryan White Title I
Ronald Rojas, Fiscal Director, Ryan White Title I
Javier Romero, Director, AIDS Drug Assistance Program
Isabel Martinee, Pharmacy Manager, Mercy Professional Pharmacy
Gary Snider, Operations Manager, Automated Case Management Systems, Inc.
Judith K. Williams, President, Williams, Stern & Associates, Inc.
Miami-Dade HIV/AIDS Partnership

RYAN WHITE NUTRITIONAL SUPPLEMENTS
Letter of Medical Necessity for Supplementation in ADULTS

Date: _____

As the primary medical caretaker for _____, who has a diagnosis of HIV/AIDS, it is my considered opinion that he/she requires enteric nutritional supplements.

I believe that nutritional supplements are medically indicated in this case and I have referred this patient for a professional Nutritional Assessment by a Registered Dietitian/Nutritionist.

I understand enteral nutrition must be evaluated by a Dietitian/Nutritionist every _____. *(Please indicate period of time for nutritional re-evaluation. Number of refills authorized cannot exceed this period of time.)*

Sincerely,

_____, M. D./ D.O./ ARNP/ PA-C
SIGNATURE
(Physician, Nurse Practitioner or Physician Assistant)

_____ _____
PRINT NAME Florida Medical License #
(Physician, Nurse Practitioner or Physician Assistant)

_____
PRINT NAME
(Registered Dietitian/Nutritionist)

_____ _____
SIGNATURE Dietitian/Nutritionist Florida License #
(Registered Dietitian/Nutritionist)

Nutrition Products Available Through Ryan White Title I

Physician/ Nurse Practitioner/ Physician Assistant/ Dietitian/Nutritionist, please indicate preferred product, flavor, number of servings recommended and number of refills authorized. *(Dietitian/Nutritionist, please refer to the Criteria for Dispensing Nutritional Supplements FORM for patient's nutritional assessment on back page.)*

Please document patient's: Height: _____ Weight: _____ ☐ Lbs ☐ Kgs IBW/UBW: _____ ☐ Lbs ☐ Kgs

NOTE: *1 Serving = 2 Scoops*

☐ Progain Powder - ___ No. of **SERVINGS per DAY** ☐ Vanilla ☐ Chocolate
(HIGH calorie product)
Number of Refills Authorized _____
(Number of refills authorized cannot exceed period of time for re-evaluation by nutritionist/dietitian as indicated above)

☐ IgG Pure - ___ No. of **SERVINGS per DAY** (Only natural flavor available)
(LOW calorie product)
Number of Refills Authorized _____
(Number of refills authorized cannot exceed period of time for re-evaluation by nutritionist/ dietitian as indicated above)

Please note: If the patient is on MEDICAID, please refer to the MEDICAID Medical Necessity Request Letter.
Patient's 10 digit MEDICAID Number: _____

RYAN WHITE NUTRITIONAL SUPPLEMENTS
Letter of Medical Necessity for Supplementation in CHILDREN

Date: _____

As the primary medical caretaker for _____, who has a diagnosis of HIV/AIDS, it is my considered opinion that he/she requires enteric nutritional supplements.

I believe that nutritional supplements are medically indicated in this case and I have referred this patient for a professional Nutritional Assessment by a Registered Dietitian/Nutritionist.

I understand enteral nutrition must be evaluated by a Dietitian/Nutritionist every _____. *(Please indicate period of time for nutritional re-evaluation. Number of refills authorized cannot exceed this period of time.)*

Sincerely,

_____, M. D./ D.O./ ARNP/ PA-C
SIGNATURE
(Physician, Nurse Practitioner or Physician Assistant)

_____ _____
PRINT NAME Florida Medical License #
(Physician, Nurse Practitioner or Physician Assistant)

_____
PRINT NAME
(Registered Dietitian/Nutritionist)

_____ _____
SIGNATURE Dietitian/Nutritionist Florida License #
(Registered Dietitian/Nutritionist)

Nutrition Products Available Through Ryan White Title I

Physician/ Nurse Practitioner/ Physician Assistant/ Dietitian/ Nutritionist, please indicate preferred product, flavor, number of servings recommended and number of refills authorized. *(Dietitian/Nutritionist, please refer to the Criteria for Dispensing Nutritional Supplements FORM for patient's nutritional assessment on back page.)*

Please document patient's: Height: _____ Weight: _____ ☐ Lbs ☐ Kgs IBW/UBW: _____ ☐ Lbs ☐ Kgs

NOTE: *1 Serving = 1 Can (8 fluid ounces)*

Boost Liquid is restricted to Children 18 years and under

Boost Liquid- _____ No. of **SERVINGS per DAY**
Number of Refills Authorized _____
(Number of refills authorized cannot exceed period of time for re-evaluation by nutritionist/ dietitian as indicated above.)

Please indicate FLAVOR preference: ☐ Vanilla ☐ Chocolate ☐ Strawberry

Resource Just for Kids is restricted to Children 1 - 10 years of age

Resource Just for Kids- _____ No. of **SERVINGS per DAY**
Number of Refills Authorized _____

Please note: If the patient is on MEDICAID, please refer to the MEDICAID Medical Necessity Request Letter.
Patient's 10 digit MEDICAID Number: _____
Rev. 03/11/02

RYAN WHITE TITLE I

CRITERIA FOR DISPENSING NUTRITIONAL SUPPLEMENTS

The following are potential situations where commercial nutritional supplements could be considered medically indicated.

Patient must meet at least two (2) criteria listed below.
(Consultation with a Registered Dietitian/Nutritionist for nutritional assessment and a Letter of Medical Necessity are required.)

Please check all that apply:

___ Current body weight < 10% IBW/UBW
___ Weight loss of:
- 5% of the initial/baseline weight over the past month -OR-
- 7.5% over the past 3 months -OR-
- 10% weight loss within the last 6 months

___ Body Cell Mass (BCM) < 40% (MALES) or BCM < 35% (FEMALE) of IBW
___ Body Mass Index (BMI) < 20
___ Recent illness/hospitalization that will interfere with patient's ability to consume or tolerate adequate non-supplemental nutrition
___ Diarrhea/malabsorption with > 3 large, liquid stools/day
___ Dysphagia and/or odonyphagia where commercial supplements are the only source of nutrition tolerated
___ Serum albumin < 3.5 g/dl
___ Failure to gain/maintain weight in the past when following a dietary regimen to promote weight gain
___ Inadequate living conditions or inability to buy/prepare meals
___ Inability to understand and or follow nutritional recommendations

NUTRITIONAL PLAN FOR SUPPLEMENTS

I. INITIAL Consultation: Date: _____ Weight: _____

Patient assessed/instructed by Registered Dietitian/Nutritionist: **(Please check the appropriate box)**

☐ Nutritional supplements **recommended** ☐ Nutritional supplements **NOT** recommended

II. FOLLOW-UP Visit: Date: _____ Weight: _____

Patient re-assessed for progress: **(Please check the appropriate box)**

☐ Nutritional supplements **continued** ☐ Nutritional supplements **discontinued**

III. ADDT'L FOLLOW-UP Visit: Date: _____ Weight: _____

Patient re-assessed for progress: **(Please check the appropriate box)**

☐ Nutritional supplements **continued** ☐ Nutritional supplements **discontinued**

RYAN WHITE TITLE I PROGRAM
Letter of Medical Necessity to Accompany Initial Prescription for Testosterone Gel (Androgel® 1%)
(MUST ACCOMPANY INITIAL REFERRAL TO THE PHARMACY ALONG WITH A PRESCRIPTION)

Date: _____

As the prescribing physician for _____, who has a diagnosis of low serum testosterone level*, it is my opinion that testosterone replacement with testosterone gel (Androgel® 1%) is medically necessary for this patient. The following criteria have been met and required information submitted.

The medication will be utilized to treat low serum testosterone level* **if** the following are met:

1. The patient has a documented history of prior intramuscular (IM) long acting testosterone use for _____ (amount of time).

2. There is an existing contraindication to the injectable formulation whereby the patient has a history of a medical condition in which the use of the different intramuscular injection sites is contraindicated (i.e., infection/abscess at all injection sites). **Please specify the reason for the contraindication** (check the appropriate box):

   - ☐ Hemophilia
   - ☐ Anticoagulation – patient is on Coumadin
   - ☐ Infection/small abscess at injection site until infection resolves
   - ☐ Thrombocytopenia

   Please provide the following ***PATIENT INFORMATION***:

DATE parameter measured:	PARAMETERS			
	Height:			
	Weight:	Lbs	or	Kg
	Serum Testosterone Level:			

* A testosterone level below normal as measured by the reference lab. Please submit with the **initial** referral and prescription a copy of the dated lab report with testosterone level results.

Sincerely,

_____, M.D.
SIGNATURE

_____ _____
PRINT NAME (Physician) | Florida Medical License # (MEO#)

_____ _____
Patient's 10 digit Medicaid # (if applicable) | Patient's CIS # (assigned by the Ryan White Title I Service Delivery Information System)

Please note: All questions should be addressed to Ms. Yocasta Juliao, Ryan White Title I Project Director, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee.

Pursuant to Article VI, Section 6.4 (H) of the Ryan White Title I service agreement, Miami-Dade County has the right to access all client files (including electronic files), service utilization data, and medical records during on site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.

Rev. 08/22/03

RFP No. RW1401
ATTACHMENT 21e

RYAN WHITE TITLE I PROGRAM
Letter of Medical Necessity for
Antiretroviral Resistance Assays

Date:_____

As the primary medical caretaker for _____, who has a diagnosis of _____, it is my considered opinion that he/she requires genotypic resistance testing. The patient's prognosis is _____. The following criteria have been met:

1. The patient has sub-optimal suppression of the viral load following initiation of antiretroviral therapy as defined by the current medical guidelines of the Department of Health and Human Services.

2. The patient has failed multiple antiretroviral regimens as defined by the current medical guidelines of the Department of Health and Human Services.

I understand genotypic resistance testing may only be ordered under the following conditions:

1. The above criteria have been met and are fully documented in the patient's medical record;
2. The patient must have been fully adherent to his/her current antiretroviral treatment regimen;
3. Adherence has been discussed with the patient on an on-going basis as part of his/her medical treatment;
4. The patient's plasma HIV RNA (viral load) at the time of testing must be at least 1000 co/ml;
5. The patient must be on antiretroviral medications at the time of testing; and
6. Maximum of two (2) tests may be ordered in any consecutive twelve month period.

Sincerely,

_____, M.D.

_____ _____
Print Physician's name Florida Medical License # (MEO#)

_____ _____
Patient's 10 digit Medicaid # (if applicable) Patient's CIS # (assigned by the Ryan White Title I Service Delivery Information System)

Please note: All questions should be addressed to Ms. Yocasta Juliao, Ryan White Title I Project Director, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee.

Pursuant to Article VI, Section 6.4 (H) of the Ryan White Title I Professional Service Agreement, Miami-Dade County has the right to access all client files (including electronic files), service utilization data, and medical records during on site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.

RFP No. RW1401
ATTACHMENT 21f

RYAN WHITE TITLE I PROGRAM
Letter of Medical Necessity for Sporanox

Date:_____

As the primary medical caretaker for _____, who has a diagnosis of _____, it is my considered opinion that he/she requires a prescription to take Sporanox in capsule formulation. The patient's prognosis is _____. The following criteria have been met:

1. The medication will be utilized to treat one of the following two conditions (please check one box):

☐ Histoplasmosis

☐ Aspergillosis

I understand Sporanox may only be prescribed under the following conditions:

1. The above criteria have been met and are fully documented in the patient's medical record
2. The patient has been diagnosed with either histoplasmosis or aspergillosis.

Sincerely,

_____, M.D.

_____ Print M.D.'s name

_____ Florida medical license # (MEO#)

_____ Patient's 10 digit Medicaid # (if applicable)

_____ Patient's CIS # (assigned by the Ryan White Title I Service Delivery Information System)

Please note: All questions should be addressed to Ms. Yocasta Juliao, Ryan White Title I Project Director, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee.

Pursuant to Article VI, Section 6.4 (H) of the Ryan White Title I service agreement, Miami-Dade County has the right to access all client files (including electronic files), service utilization data, and medical records during on site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.

RYAN WHITE TITLE I PROGRAM
Letter of Medical Necessity for Valacyclovir (NEW PRESCRIPTIONS)

Date:_____

As the primary medical caretaker for _____, who has a diagnosis of _____, it is my considered opinion that (check **one** of the following)

☐ Valacyclovir 500mg

☐ Valacyclovir 1000mg

is medically necessary for this patient. The following criteria has been identified and documented in the patient's chart (the physician must initial next to the box corresponding to the medical condition that applies to this patient):

☐ This Patient requires Valacyclovir daily suppressive therapy (usual dose is 500mg twice daily) for recurrent Herpes Simplex episodes occurring while receiving standard doses of daily suppressive Acyclovir therapy (usual doses are between 400mg and 800mg twice to three times daily).

☐ This patient has acute Herpes Zoster, and requires Valacyclovir 1000mg three (3) times daily. A ten (10)-day supply, refillable once only, may be provided per episode.

OR

Note: To qualify for daily suppressive Valacyclovir therapy, a patient must have had more than one Herpes recurrence while receiving daily Acyclovir suppressive therapy. This must be documented by attaching a photocopy of a recent Acyclovir prescription to this Letter of Medical Necessity when submitted with the first prescription for Valacyclovir tablets. This is not a requirement for subsequent refills.

I understand Valacyclovir may only be prescribed when one of the criteria specified above has been met and is fully documented in the patient's medical record.

Sincerely,

_____, M.D.

_____ _____
Print M.D.'s Name Florida Medical License # (MEO#)

_____ _____
Patient's 10 Digit Medicaid # (if applicable) Patient's CIS #
(ID number assigned by the Ryan White Title I Service Delivery Information System)

Please note: All questions should be addressed to Ms. Yocasta Juliao, Ryan White Title I Project Director, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee.

Pursuant to Article VI, Section 6.4 (H) of the Ryan White Title I service agreement, Miami-Dade County has the right to access all client files (including electronic files), service utilization data, and medical records during on site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.

Rev. 7/12/02

RFP No. RW1401
ATTACHMENT 21h

RYAN WHITE TITLE I PROGRAM
Letter of Medical Necessity for Pantoprazole
(Must be completed by a Gastroenterologist)

Date:_____

I, _____, a Board-Certified gastroenterologist, hereby certify that _____, is a patient under my care who requires Protonix 40 mg for the treatment of Erosive Esophagitis, or Barrett's Esoghaus, or a hypersecretory condition. I certify that a proton pump inhibitor is medically necessary.

Sincerely,

_____, M.D. (DO)

Print Physician's name	Florida Medical License # (MEO#)
Patient's 10 digit Medicaid # (if applicable)	Patient's CIS # (assigned by the Ryan White Title I Service Delivery Information System)

This letter **must** be completed each time a new Protonix prescription is written to treat any of the conditions indicated above. It is not required for refills.

Please note: All questions should be addressed to Ms. Yocasta Juliao, Ryan White Title I Project Director, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee.

Pursuant to Article VI, Section 6.4 (H) of the Ryan White Title I Professional Service Agreement, Miami-Dade County has the right to access all client files (including electronic files), service utilization data, and medical records during on site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.

Rev. 11/26/02

RFP No. RW1401
ATTACHMENT 21i

RYAN WHITE TITLE I PROGRAM
Letter of Medical Necessity for Olanzapine (Zyprexa)

SECTION I: **This section is to be completed by a prescribing healthcare provider for *INITIAL* Olanzapine (ZYPREXA) prescriptions NOT EXCEEDING 20mg PER DAY.**

Date: _____

As the PRESCRIBING HEALTHCARE PROVIDER for _____, who has a diagnosis of _____, it is my opinion that Olanzapine (Zyprexa) is medically necessary for this patient at a dose of _____.

I understand that a letter of medical necessity is required only for the **initial** prescription for Olanzapine (Zyprexa) **NOT** exceeding 20mg per day.

SECTION II: **This section is to be completed by a prescribing healthcare provider for *ALL* Olanzapine (ZYPREXA) prescriptions *EXCEEDING 20mg PER DAY***

Date: _____

As the PRESCRIBING HEALTHCARE PROVIDER for _____, who has a diagnosis of _____, it is my opinion that an Olanzapine (Zyprexa) dosage **exceeding** 20mg per day is medically necessary for this patient.

In addition, I am providing the following information as required by Ryan White Title I:

- Reason for Olanzapine (Zyprexa) dose > 20mg/day _____
- **Previous** Olanzapine (Zyprexa) dosage _____
- Duration of **previous** Olanzapine (Zyprexa) treatment _____

I understand that a letter of medical necessity is required for every new prescription of Olanzapine (Zyprexa) exceeding 20mg per day.

_____ _____
Signature Print Name

_____ _____
Florida medical license # (MEO#) Patient's 10 digit Medicaid # (if applicable)

_____
Patient's CIS # (assigned by the Ryan White Title I Service Delivery Information System)

Please note: All questions should be addressed to Ms. Yocasta Juliao, Ryan White Title I Project Director, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee (Physician, Nurse, Dietician, Nutritionist, etc.).

Pursuant to Article VI, Section 6.4 (H) of the Ryan White Title I service agreement, Miami-Dade County has the right to access all client files (including electronic files), service utilization data, and medical records during on-site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.

RYAN WHITE TITLE I
DURABLE MEDICAL EQUIPMENT AND SUPPLIES
LETTER OF MEDICAL NECESSITY

(THIS DOCUMENT MUST BE ACCOMPANIED BY A DOCTOR'S PRESCRIPTION)

Date: _____

PART I - Physician's Certification

As the primary physician for _____, who has a diagnosis of *(HIV+ Symptomatic or AIDS)* _____, it is my opinion that he/she requires the following medical equipment and/or supplies due to a prognosis of _____:

Equipment _____ Quantity_____

_____

Supplies _____ Quantity _____

_____

The medical **equipment** indicated above is necessary in order to ensure the patient's well being for the time period of _____ .

The medical **supplies** indicated above are necessary in order to ensure the patient's well being for the time period of _____ .

_____ _____
Physician's Signature Date

_____ (_____)_____
Physician's Florida Medical License Number Physician's Telephone Number

_____
Agency Name

PART II - Case Manager's Certification

To be Completed by Title I Funded Case Managers

As the primary case manager for _____, CIS #:_____, Agency Assigned ID #:_____, I certify that he/she has been screened for eligibility under Title I and other funding sources. Title I (funding source of last resort) is the only program that can currently meet this client's needs for all of the equipment and/or supplies indicated above or for some of the items listed depending on the limitations defined by other benefit programs. As a Title I funded provider, I understand that this Letter of Medical Necessity, along with the attached physician's order for the above mentioned equipment and/or supplies, constitutes a certified referral for this service and confirms this client's medical and financial eligibility under the Title I program.

RYAN WHITE TITLE I
DURABLE MEDICAL EQUIPMENT AND SUPPLIES
LETTER OF MEDICAL NECESSITY

(THIS DOCUMENT MUST BE ACCOMPANIED BY A DOCTOR'S PRESCRIPTION)

PART II - Case Manager's Certification (Continued)

To be Completed by Non-Title I Funded Case Managers

As the primary case manager for _____, Agency Assigned ID #:_____, I certify that he/she has been screened for eligibility under funding sources other than Title I. Title I (funding source of last resort) is the only program that can currently meet this client's needs for all of the equipment and/or supplies indicated above or for some of the items listed depending on the limitations defined by other benefit programs. As a non-Title I funded case manager, I understand that this Letter of Medical Necessity must be accompanied by documentation of the client's medical and financial eligibility in order for the client to receive this service under the Title I program. Therefore, the required proof of eligibility is hereby attached.

_____ _____
Case Manager's Signature Date

_____ (_____)_____
Agency Name Case Manager's Telephone Number

RFP No. RW1401
ATTACHMENT 21k

RYAN WHITE TITLE I PROGRAM
Letter of Medical Necessity for
Appetite Stimulant

Date:_____

As the prescribing physician for _____, who has a diagnosis of _____, it is my opinion that an appetite stimulant is medically necessary for this patient (check the appropriate box):

☐ Dronabinol (Marinol) –maximum of 2.5mg b.i.d. dosage*

☐ Megestrol (Megace)

☐ Pancrelipase (Ultrase)

[***NOTE:** Title I funds may only be used to cover a maximum of 2.5 mg b.i.d. dosage of Dronabinol (Marinol).]

The patient's prognosis is _____.

The physician prescribing this medication **MUST** sign and date the Letter of Medical Necessity for Appetite Stimulant attesting to the following:

1. This appetite stimulant will play a vital role in maintaining the patient's degree of wellness by preventing malnutrition, pancreatic and/or digestive insufficiency. This patient has failed to gain or maintain weight with a standard dietary intake. Without this medication this patient will have to be hospitalized.
2. I have tried other dietary regimens such as high calorie high protein meals, pureed food, fortified milkshakes, etc., with my patient with no results. I believe that the appetite stimulant _____ is medically indicated in this case.
3. I understand the need for this appetite stimulant to be reassessed every month and for a Letter of Medical Necessity for Appetite Stimulant to be completed on a monthly basis.

Sincerely,

Patient's Height _____

_____, M.D.
SIGNATURE

Patient's Weight _____

_____
PRINT NAME
(Physician)

_____
Florida Medical License # (MEO#)

_____
Patient's 10 digit Medicaid # (if applicable)

_____
Patient's CIS # (assigned by the Ryan White Title I Service Delivery Information System)

Please note: All questions should be addressed to Ms. Yocasta Juliao, Ryan White Title I Project Director, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee.

Pursuant to Article VI, Section 6.4 (H) of the Ryan White Title I service agreement, Miami-Dade County has the right to access all client files (including electronic files), service utilization data, and medical records during on site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.

RYAN WHITE TITLE I PROGRAM
Prior Authorization Form for Procrit® (Epoetin)

Recipient's Full Name:_____ Date of Birth: _____ /_____ /_____
Prescriber Full Name:_____ Prescriber License #: (ME,OS,RN)_____
Prescriber Telephone #:_____ Prescriber Fax #:_____
Drug Strength: _____

Please check below the diagnosis or indication for this product:

☐ Anemia associated with HIV
☐ Anemia associated with renal failure if patient is not on dialysis
☐ Anemia associated with chemotherapy
☐ Other _____

Select one of the following:

New Therapy ☐ **OR** Continuation of Therapy ☐

Does the patient have active gastrointestinal bleeding? ☐ YES **OR** ☐ NO

Lab Test Date:_____ Hematocrit:_____% Hemoglobin:_____g/dl

Indicate dosage and frequency of dosing: _____

Prescriber's Signature: _____

Please attach a copy of the original prescription and lab results dated within the last two (2) months.

Mail or Fax information to: Mercy Professional Pharmacy
3661 South Miami Avenue, Suite 110
Miami, FL 33133
Telephone #: (305) 285-2762 (for information only)
Fax #: (305) 285-5019 **OR** (305) 285-2606

FOR RYAN WHITE TITLE I USE ONLY

Date: _____ **Notified:** _____

Approved: _____ **Start Date:** _____ **Expiration Date:** _____

Denied: _____ **Reason:** _____

Please note: All questions should be addressed to Ms. Yocasta Juliao, Ryan White Title I Project Director, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee.

Pursuant to Article VI, Section 6.4 (H) of the Ryan White Title I Professional Service Agreement, Miami-Dade County has the right to access all client files (including electronic files), service utilization data, and medical records during on site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.

RYAN WHITE TITLE I PROGRAM
Prior Authorization Form for Neupogen® (Filgrastim)

Recipient's Full Name:_____ Date of Birth: _____ /_____ /_____
Prescriber Full Name:_____ Prescriber License #: (ME,OS,RN)_____
Prescriber Telephone #:_____ Prescriber Fax #:_____
Drug Strength: _____

Please check below the diagnosis or indication for this product:

☐ Severe neutropenia in AIDS patients on antiretroviral therapy
Severe Chronic Neutropenia: ☐ congenital ☐ cyclic ☐ idiopathic
☐ Cancer patients with HIV/AIDS receiving myelosuppressive chemotherapy

Select one of the following:

New Therapy ☐ **OR** Continuation of Therapy ☐

Lab Test Date: _____ Absolute Neutrophil Count: _____ cells/mm3

What is the date range of therapy? Begin Date: _____ End Date: _____

Indicate dosage and frequency of dosing: _____

Prescriber's Signature: _____

Please attach a copy of the original prescription and lab results dated within the last three (3) months.

Mail or Fax information to: Mercy Professional Pharmacy
3661 South Miami Avenue, Suite 110
Miami, FL 33133
Telephone #: (305) 285-2762 (for information only)
Fax #: (305) 285-5019 **OR** (305) 285-2606

FOR RYAN WHITE TITLE I USE ONLY

Date: _____ **Notified:** _____

Approved: _____ **Start Date:** _____ **Expiration Date:** _____

Denied: _____ **Reason:** _____

Please note: All questions should be addressed to Ms. Yocasta Juliao, Ryan White Title I Project Director, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee.

Pursuant to Article VI, Section 6.4 (H) of the Ryan White Title I Professional Service Agreement, Miami-Dade County has the right to access all client files (including electronic files), service utilization data, and medical records during on site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.

RFP No. RW1401
ATTACHMENT 21n

PRESCRIPTION DRUGS - CONSUMABLE MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT PRICE LIST*

Organization	Budget Period

*Equipment/Supply Code	*Description of Equipment/Supply	Brand Name and/or Additional Specifications	Item Cost

(*PLEASE NOTE: THIS PRICE LIST MUST ONLY INCLUDE CONSUMABLE MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT THAT ARE REQUIRED TO ADMINISTER PRESCRIBED MEDICATIONS.)

Signature	Name (Print or Type)

Title

Corporate Seal

OR

Sworn to and subscribed before me
this _____ day of _____, 2004.

NOTARY PUBLIC, State of Florida at Large

Instructions for Completing the
Prescription Drugs – Consumable Medical Supplies and Durable Medical Equipment (DME) Price List Form

1. In the box titled *"Organization,"* please type the full legal name of the proposing organization.

2. In the box titled *"Budget Period,"* please indicate the time period (mm/dd/yy - mm/dd/yy) for which the proposing organization will provide services if the proposing organization is awarded the full amount of its request.

3. Under the column titled *"Equipment/Supply Code,"* please list, in numeric order, the 2004 Medicare Part B Fee Schedule (Participating, Loc. 04) code for each consumable medical supply and durable medical equipment item required to administer prescribed medications that the proposing organization will provide if the organization is awarded the full amount of its request. If no Medicare code is available, use the Durable Medical Equipment (DME) Medicaid Handbook code. **Please be reminded that the Medicaid code is to be utilized only for the purposes of identifying durable medical equipment. For supplies, please enter "S".**

4. Under the column titled *"Description of Equipment/Supply,"* please provide a written description for the equipment/supply item that corresponds to each code listed.

5. Please complete the column titled *"Brand Name and/or Additional Specifications,"* by indicating the brand name or specification of the item(s) listed in Item #4 above.

6. Under the column titled *"Item Cost,"* please indicate the proposing organization's cost for each equipment or supply item.

NOTE: **A Multiplier rate may be applied to the allowable supply and equipment rate as listed in the 2004 Medicare Part B Fee Schedule (Participating, Loc. 04). If no Medicare Rate is available, providers would be reimbursed at the DME Medicaid Handbook Rate, effective March 2003. If no Medicare or Medicaid rate is available, providers would submit a request for a Supplementary Reimbursement Rate. No multiplier may be applied to the supplemental rate. The maximum multiplier rate for Medicare is 1.10 and the maximum multiplier rate for Medicaid is 1.50.**

7. In the box titled *"Signature,"* please have an officer of the proposing organization, who is legally authorized to enter into a contractual relationship in the name of the proposing organization, sign this Price Form.

8. In the box titled *"Name,"* please print legibly or type the name of the officer whose signature appears in the "Signature" box of this Price List Form.

9. In the box labeled *"Title,"* please type the signing officer's title or position in the proposing organization.

NOTE: **Either instruction number 10 or 11 must be followed in order for this document to be deemed adequate and thus considered for possible contract award.**

10. In the box titled *"Corporate Seal,"* please affix the proposing organization's corporate seal, if available.

11. If a corporate seal is not available, please have this Price Form notarized in the box provided under the statement *"Sworn to and subscribed before me this__ day of__ , 2004."*

NOTE: **Proposing organizations are reminded that a categorical (line item) budget, including a narrative justification and a detailed description of how unit cost(s) were calculated, MUST be submitted with this Price Form. Failure to submit this information will disqualify the organization's proposal from further consideration.**

RFP No. RW1401
ATTACHMENT 22

PRICE FORM

Instructions for completing the Case Management "General HIV/AIDS Population" Price Form are provided on the reverse side of this document.

CASE MANAGEMENT (General HIV/AIDS Population)

Organization	# of Unduplicated Clients to be Served

Face-to-Face Encounter (FFE):

Number of 15 Minute Encounters		Per 15 Minute Encounter Cost*		Total Request
	X		=	

Other Encounter (OTH):

Number of 15 Minute Encounters		Per 15 Minute Encounter Cost*		Total Request
	X		=	

Signature	Name (Print or Type)	Title

Corporate Seal

OR

Sworn to and subscribed before me
this day of , 2004.

NOTARY PUBLIC, State of Florida
at Large

**NOTE - Rate may not exceed $12.50 per 15 minute encounter.*

LL1

Instructions for Completing
Case Management (General HIV/AIDS Population)
Price Form

1. In the box titled *"Organization,"* please type the full legal name of the proposing organization.

2. In the box titled *"# of Unduplicated Clients to be Served,"* please type the estimated number of eligible clients (counting each client only once) that will be provided case management services if the proposing organization is awarded the full amount of its request.

3. In the boxes titled *"Number of 15 Minutes Encounters,"* please type the total number of face-to-face encounters and/or other encounters (i.e., telephone conversations with the client or on behalf of the client) that will be provided if the proposing organization is awarded the full amount of its request.

4. In the boxes titled *"Per 15 Minute Encounter Cost,"* please type the proposing organization's cost for each case management encounter. **Rates may not exceed $12.50 per 15-minute encounter.**

5. In the boxes titled *"Total Request,"* please type the total dollar amount that the proposing organization is requesting for each type of case management encounter.

6. In the box titled *"Signature,"* please have an officer of the proposing organization, who is legally authorized to enter into a contractual relationship in the name of the proposing organization, sign this Price Form.

7. In the box titled *"Name,"* please print legibly or type the name of the officer whose signature appears in the "Signature" box of this Price Form.

8. In the box labeled *"Title,"* please type the signing officer's title or position in the proposing organization.

NOTE: **Either instruction number 9 or 10 must be followed in order for this document to be deemed adequate and thus considered for possible contract award.**

9. In the box titled *"Corporate Seal,"* please affix the proposing organization's corporate seal, if available.

10. If a corporate seal is not available, please have this Price Form notarized in the box provided under the statement *"Sworn to and subscribed before me this __ day of __, 2004".*

NOTE: **Proposing organizations are reminded that a categorical (line item) budget, including a narrative justification and a detailed description of how unit cost(s) were calculated, MUST be submitted with this Price Form. Failure to submit this information will disqualify the organization's proposal from further consideration.**

RFP No. RW1401
ATTACHMENT 22a

PRICE FORM

Instructions for completing the PESN "General HIV/AIDS Population" Price Form are provided on the reverse side of this document.

PEER EDUCATION SUPPORT NETWORK (PESN) (General HIV/AIDS Population)

Organization	# of Unduplicated Clients to be Served	Budget Period

Face-to-Face Encounter (FFE):

Number of 15 Minute Encounters		Per 15 Minute Encounter Cost*		Total Request
	X		=	

Other Encounter (OTH):

Number of 15 Minute Encounters		Per 15 Minute Encounter Cost*		Total Request
	X		=	

Signature	Name (Print or Type)	Title

Corporate Seal

OR

Sworn to and subscribed before me
this day of , 2004.

NOTARY PUBLIC, State of Florida
at Large

NOTE - Rate may not exceed $6.25 per 15 minute encounter.

Instructions for Completing
Peer Education Support Network (General HIV/AIDS Population)
Price Form

1. In the box titled *"Organization,"* please type the full legal name of the proposing organization.

2. In the box titled *"# of Unduplicated Clients to be Served,"* please type the estimated number of eligible clients (counting each client only once) that will be provided Peer Education Support Network (PESN) case management services if the proposing organization is awarded the full amount of its request.

3. In the boxes titled "*Number of 15 Minutes Encounters*," please type the total number of face-to-face encounters and/or other encounters (i.e., telephone conversations with the client or on behalf of the client, including travel time for "Peer" services for homebound clients only), that the proposing organization will provide if the organization is awarded the full amount of its request.

4. In the boxes titled "*Per 15 Minute Encounter Cost*," please type the proposing organization's cost for each PESN case management encounter. **Rates may not exceed $6.25 per 15-minute encounter.**

5. In the boxes titled *"Total Request,"* please type the total dollar amount that the proposing organization is requesting for each type of PESN encounter.

6. In the box titled *"Signature,"* please have an officer of the proposing organization, who is legally authorized to enter into a contractual relationship in the name of the proposing organization, sign this Price Form.

7. In the box titled *"Name,"* please print legibly or type the name of the officer whose signature appears in the "Signature" box of this Price Form.

8. In the box labeled *"Title,"* please type the signing officer's title or position in the proposing organization.

NOTE: **Either instruction number 9 or 10 must be followed in order for this document to be deemed adequate and thus considered for possible contract award.**

9. In the box titled *"Corporate Seal,"* please affix the proposing organization's corporate seal, if available.

10. If a corporate seal is not available, please have this Price Form notarized in the box provided under the statement *"Sworn to and subscribed before me this __ day of __, 2004".*

NOTE: **Proposing organizations are reminded that a categorical (line item) budget, including a narrative justification and a detailed description of how unit cost(s) were calculated, MUST be submitted with this Price Form. Failure to submit this information will disqualify the organization's proposal from further consideration.**

RFP No. RW1401
ATTACHMENT 22b

PRICE FORM

Instructions for completing the Minority AIDS Initiative (MAI) Case Management Price Form are provided on the reverse side of this document.

MAI CASE MANAGEMENT (TARGETING MINORITY POPULATIONS)

Organization	# of Unduplicated Clients to be served

Please specify the percentage of unduplicated clients in each target minority population to be served (must add to 100%)	
Black/African American *(including Haitian Community)*	____%
Hispanic	____%
Native American	____%
Other (Specify _____)	____%
Total	**100%**

Face-to-Face Encounter (FFE):

Number of 15 Minute Encounters		Per 15 Minute Encounter Cost*		Total Request
	X		=	

Other Encounter (OTH):

Number of 15 Minute Encounters		Per 15 Minute Encounter Cost*		Total Request
	X		=	

Signature	Name (Print or Type)	Title

Corporate Seal

Sworn to and subscribed before me
this day of , 2004.

OR

NOTARY PUBLIC, State of Florida
at Large

NOTE - Rate may not exceed $12.50 per 15-minute encounter.

Instructions for Completing
Minority AIDS Initiative (MAI) Case Management
Price Form

1. In the box titled *"Organization,"* please type the full legal name of the proposing organization.

2. In the box titled *"# of Unduplicated Clients to be Served,"* please type the estimated number of eligible clients (counting each client only once) that will be provided MAI case management services if the proposing organization is awarded the full amount of its request.

3. In the box titled *"Please specify the percentage of unduplicated clients in each target minority population to be served,"* please type the estimated percentage of Black/African Americans (including Haitian Community), Hispanic, Native American or other minorities that will provided MAI case management services. All the percentages must add to 100.

4. In the boxes titled *"Number of 15 Minutes Encounters,"* please type the total number of face-to-face encounters and/or other encounters (i.e., telephone conversations with the client or on behalf of the client) that will be provided if the proposing organization is awarded the full amount of its request.

5. In the boxes titled *"Per 15 Minute Encounter Cost,"* please type the proposing organization's cost for each MAI case management encounter. **Rates may not exceed $12.50 per 15-minute encounter.**

6. In the boxes titled *"Total Request,"* please type the total dollar amount that the proposing organization is requesting for each type of MAI case management encounter.

7. In the box titled *"Signature,"* please have an officer of the proposing organization, who is legally authorized to enter into a contractual relationship in the name of the proposing organization, sign this Price Form.

8. In the box titled *"Name,"* please print legibly or type the name of the officer whose signature appears in the "Signature" box of this Price Form.

9. In the box labeled *"Title,"* please type the signing officer's title or position in the proposing organization.

NOTE: **Either instruction number 10 or 11 must be followed in order for this document to be deemed adequate and thus considered for possible contract award.**

10. In the box titled *"Corporate Seal,"* please affix the proposing organization's corporate seal, if available.

11. If a corporate seal is not available, please have this Price Form notarized in the box provided under the statement *"Sworn to and subscribed before me this __ day of __, 2004".*

NOTE: **Proposing organizations are reminded that a categorical (line item) budget, including a narrative justification and a detailed description of how unit cost(s) were calculated, MUST be submitted with this Price Form. Failure to submit this information will disqualify the organization's proposal from further consideration.**

RFP No. RW1401
ATTACHMENT 22c

PRICE FORM

Instructions for completing the Minority AIDS Initiative (MAI) PESN Price Form are provided on the reverse side of this document.

MAI PEER EDUCATION SUPPORT NETWORK (TARGETING MINORITY POPULATIONS)

Organization	# of Unduplicated Clients to be served

Please specify the percentage of unduplicated clients in each target minority population to be served (must add to 100%)

Black/African American *(including Haitian Community)*	____%
Hispanic	____%
Native American	____%
Other (Specify _____)	____%
Total	**100%**

Face-to-Face Encounter (FFE):

Number of 15 Minute Encounters		Per 15 Minute Encounter Cost*		Total Request
	X		=	

Other Encounter (OTH):

Number of 15 Minute Encounters		Per 15 Minute Encounter Cost*		Total Request
	X		=	

Signature	Name (Print or Type)	Title

Corporate Seal

Sworn to and subscribed before me
this day of , 2004.

OR

NOTARY PUBLIC, State of Florida
at Large

NOTE - Rate may not exceed $6.25 per 15-minute encounter.

Instructions for Completing
Minority AIDS Initiative (MAI) Peer Education Support Network
Price Form

1. In the box titled *"Organization,"* please type the full legal name of the proposing organization.

2. In the box titled *"# of Unduplicated Clients to be Served,"* please type the estimated number of eligible clients (counting each client only once) that will be provided MAI Peer Education Support Network (PESN) case management services if the proposing organization is awarded the full amount of its request.

3. In the box titled *"Please specify the percentage of unduplicated clients in each target minority population to be served,"* please type the estimated percentage of Black/African Americans (including Haitian Community), Hispanic, Native American or other minorities that will be provided MAI PESN services. All the percentages must add to 100.

4. In the boxes titled "*Number of 15 Minutes Encounters*," please type the total number of face-to-face encounters and/or other encounters (i.e., telephone conversations with the client or on behalf of the client, including travel time for "Peer" services for homebound clients only), that the proposing organization will provide if the organization is awarded the full amount of its request.

5. In the boxes titled "*Per 15 Minute Encounter Cost*," please type the proposing organization's cost for each MAI PESN encounter. **Rates may not exceed $6.25 per 15-minute encounter.**

6. In the boxes titled *"Total Request,"* please type the total dollar amount that the proposing organization is requesting for each type of MAI PESN encounter.

7. In the box titled *"Signature,"* please have an officer of the proposing organization, who is legally authorized to enter into a contractual relationship in the name of the proposing organization, sign this Price Form.

8. In the box titled *"Name,"* please print legibly or type the name of the officer whose signature appears in the "Signature" box of this Price Form.

9. In the box labeled *"Title,"* please type the signing officer's title or position in the proposing organization.

NOTE: **Either instruction number 10 or 11 must be followed in order for this document to be deemed adequate and thus considered for possible contract award.**

10. In the box titled *"Corporate Seal,"* please affix the proposing organization's corporate seal, if available.

11. If a corporate seal is not available, please have this Price Form notarized in the box provided under the statement *"Sworn to and subscribed before me this __ day of __, 2004".*

NOTE: **Proposing organizations are reminded that a categorical (line item) budget, including a narrative justification and a detailed description of how unit cost(s) were calculated, MUST be submitted with this Price Form. Failure to submit this information will disqualify the organization's proposal from further consideration.**

RFP No. RW1401
ATTACHMENT 23

PRICE FORM

Instructions for completing the Substance Abuse Counseling - Residential Treatment Price Form are provided on the reverse side of this document.

SUBSTANCE ABUSE COUNSELING - RESIDENTIAL TREATMENT

Organization	# of Unduplicated Clients to be Served

Number of Days		Cost per Day*		Total Request
	X		=	

Signature	Name (Print or Type)	Title

Corporate Seal

Sworn to and subscribed before me
this day of , 2004.

OR

NOTARY PUBLIC, State of Florida
at Large

**NOTE - The cost per day may not exceed $100.00.*

Instructions for Completing
Substance Abuse Counseling-Residential Treatment Price Form

1. In the box titled *"Organization,"* please type the full legal name of the proposing organization.

2. In the box titled *"# of Unduplicated Clients to be Served,"* please type the estimated number of eligible clients (counting each client only once) that will be provided substance abuse counseling residential treatment if the proposing organization is awarded the full amount of its request.

3. In the box titled *"Number of Days,"* please type the number of residential days that the proposing organization will provide of substance abuse counseling residential treatment if the proposing organization is awarded the full amount of its request.

4. In the box titled *"Cost per Day,"* please type the proposing organization's rate per day for the provision of one day of substance abuse counseling residential treatment. **The cost per day may not exceed $100.00.**

5. In the box titled *"Total Request,"* please type the total dollar amount that the proposing organization is requesting for substance abuse counseling residential treatment services.

6. In the box titled *"Signature,"* please have an officer of the proposing organization, who is legally authorized to enter into a contractual relationship in the name of the proposing organization, sign this Price Form.

7. In the box titled *"Name,"* please print legibly or type the name of the officer whose signature appears in the "Signature" box of this Price Form.

8. In the box labeled *"Title,"* please type the signing officer's title or position in the proposing organization.

NOTE: **Either instruction number 9 or 10 must be followed in order for this document to be deemed adequate and thus considered for possible contract award.**

9. In the box titled *"Corporate Seal,"* please affix the proposing organization's corporate seal, if available.

10. If a corporate seal is not available, please have this Price Form notarized in the box provided under the statement *"Sworn to and subscribed before me this __ day of __, 2004".*

NOTE: **Proposing organizations are reminded that a categorical (line item) budget, including a narrative justification and a detailed description of how unit cost(s) were calculated, MUST be submitted with this Price Form. Failure to submit this information will disqualify the organization's proposal from further consideration.**

RFP No. RW1401
ATTACHMENT 24

PRICE FORM

Instructions for completing the Health Insurance Services (AICP) Price Form are provided on the reverse side of this document.

Health Insurance Services
AIDS Insurance Continuation Program (AICP)

Organization	# of Unduplicated Clients to be Served

Reimbursement Rate

Based on Dollars Per Insurance Premium	+	Dispensing Rate	Total Request
		$15.00/month	

Signature	Name (Print or Type)	Title

Corporate Seal

OR

Sworn to and subscribed before me
this day of , 2004.

NOTARY PUBLIC, State of Florida
at Large

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Instructions for Completing the
Health Insurance Services (AIDS Insurance Continuation Program) Price Form

1. In the box titled "*Organization,*" please type the full legal name of the proposing organization.

2. In the box titled "*# of Unduplicated Clients to be Served,*" please type the estimated number of eligible clients (counting each client only once) that will be provided with health insurance services (AIDS Insurance Continuation Program) if the proposing organization is awarded the full amount of its request.

3. In the Box titled *"Dispensing Rate,"* a standard rate of $15.00 per month will be applied to the dollars per insurance premium.

4. In the box titled "*Total Request,*" please type the total dollar amount that the proposing organization is requesting for health insurance services (AIDS Insurance Continuation Program).

5. In the box titled "*Signature,*" please have an officer of the proposing organization, who is legally authorized to enter into a contractual relationship in the name of the proposing organization, sign this Price Form.

6. In the box titled "*Name,*" please print legibly or type the name of the officer whose signature appears in the Signature box of this Price Form.

7. In the box labeled "*Title,*" please type the signing Officer's title or position in the proposing organization.

NOTE: **Either instruction number 8 or 9 must be followed in order for this document to be deemed adequate and thus considered for possible contract award.**

8. In the box titled "*Corporate Seal*" please, if available, affix the proposing organization's corporate seal.

9. If a corporate seal is not available, please have this Price Form notarized in the box provided under the statement "*Sworn to and subscribed before me this___ day of, 2004.*"

NOTE: **Proposing organizations are reminded that a categorical (line item) budget, including a narrative justification and a detailed description of how unit cost(s) were calculated, MUST be submitted with this Price Form. Failure to submit this information will disqualify the organization's proposal from further consideration.**

RFP No. RW1401
ATTACHMENT 24a

PRICE FORM

Instructions for completing the Health Insurance Services (Insurance Deductibles) Price Form are provided on the reverse side of this document.

Health Insurance Services (Insurance Deductibles)

Organization	# of Unduplicated Clients to be Served

Reimbursement Rate

Based on Dollars Per Insurance Deductible	+	Dispensing Rate (%)	Total Request

Signature	Name (Print or Type)	Title

Corporate Seal

OR

Sworn to and subscribed before me this day of , 2004.

NOTARY PUBLIC, State of Florida at Large

Instructions for Completing the
Health Insurance Services (Insurance Deductibles) Price Form

1. In the box titled "*Organization,*" please type the full legal name of the proposing organization.

2. In the box titled "*# of Unduplicated Clients to be Served,*" please type the estimated number of eligible clients (counting each client only once) that will be provided with health insurance services (insurance deductibles) if the proposing organization is awarded the full amount of its request.

3. In the Box titled *"Dispensing Rate %,"* please type the proposing organization's rate (%) to be applied to the dollars per insurance deductible.

4. In the box titled "*Total Request,*" please type the total dollar amount that the proposing organization is requesting for health insurance services (insurance deductibles).

5. In the box titled "*Signature,*" please have an officer of the proposing organization, who is legally authorized to enter into a contractual relationship in the name of the proposing organization, sign this Price Form.

6. In the box titled "*Name,*" please print legibly or type the name of the officer whose signature appears in the Signature box of this Price Form.

7. In the box labeled "*Title,*" please type the signing Officer's title or position in the proposing organization.

NOTE: **Either instruction number 8 or 9 must be followed in order for this document to be deemed adequate and thus considered for possible contract award.**

8. In the box titled "*Corporate Seal*" please, if available, affix the proposing organization's corporate seal.

9. If a corporate seal is not available, please have this Price Form notarized in the box provided under the statement "*Sworn to and subscribed before me this___ day of, 2004.*"

NOTE: **Proposing organizations are reminded that a categorical (line item) budget, including a narrative justification and a detailed description of how unit cost(s) were calculated, MUST be submitted with this Price Form. Failure to submit this information will disqualify the organization's proposal from further consideration.**

RFP No. RW1401
ATTACHMENT 24b

PRICE FORM

Instructions for completing the Health Insurance Services (Prescription Drugs Co-Payments) Price Form are provided on the reverse side of this document.

Health Insurance Services (Prescription Drugs Co-Payments)

Organization	# of Unduplicated Clients to be Served

Reimbursement Rate

Based on Dollars Per Co-Payment	+	Dispensing Rate (%)

Total Request

Signature	Name (Print or Type)	Title

Corporate Seal

OR

Sworn to and subscribed before me
this _____ day of _____, 2004.

NOTARY PUBLIC, State of Florida
at Large

Instructions for Completing the
Health Insurance Services (Prescription Drugs Co-Payments)
Price Form

1. In the box titled "*Organization*," please type the full legal name of the proposing organization.

2. In the box titled "*# of Unduplicated Clients to be Served*," please type the estimated number of eligible clients (counting each client only once) that will be provided with Health Insurance Services (prescription drugs co-payments) if the proposing organization is awarded the full amount of its request.

3. In the box titled *"Dispensing Rate (%),"* please type the proposing organization's rate (%) to be applied to the dollars per co-payment.

4. In the box titled "*Total Request*," please type the total dollar amount that the proposing organization is requesting for health insurance services (prescription drugs co-payments).

5. In the box titled "*Signature*," please have an officer of the proposing organization, who is legally authorized to enter into a contractual relationship in the name of the proposing organization, sign this Price Form.

6. In the box titled "*Name*," please print legibly or type the name of the officer whose signature appears in the Signature box of this Price Form.

7. In the box labeled "*Title*," please type the signing Officer's title or position in the proposing organization.

NOTE: **Either instruction number 8 or 9 must be followed in order for this document to be deemed adequate and thus considered for possible contract award.**

8. In the box titled "*Corporate Seal*" please, if available, affix the proposing organization's corporate seal.

9. If a corporate seal is not available, please have this Price Form notarized in the box provided under the statement "*Sworn to and subscribed before me this ___ day of, 2004.*"

NOTE: **Proposing organizations are reminded that a categorical (line item) budget, including a narrative justification and a detailed description of how unit cost(s) were calculated, MUST be submitted with this Price Form. Failure to submit this information will disqualify the organization's proposal from further consideration.**

MIAMI-DADE COUNTY
RYAN WHITE TITLE I PROGRAM

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SYSTEM-WIDE STANDARDS OF CARE

Effective August 12, 2002

RFP No. RW1401
ATTACHMENT 25

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RFP No. RW1401
ATTACHMENT 25

MIAMI-DADE COUNTY
RYAN WHITE TITLE I PROGRAM
SYSTEM-WIDE STANDARDS OF CARE

The following sets of standards are an essential component of the Ryan White Title I quality management program and form the basis for on-going monitoring and evaluation of Title I funded service providers by the Miami-Dade County Office of Management and Budget and/or its authorized representatives. It is not expected that contracted organizations be in full compliance with the System-wide Standards of Care as outlined below at the time of contract execution. It is assumed, however, that the service provider has read and understands the standards, and by signing a contract the provider is agreeing to make every effort to progress towards full compliance with these standards. The County recognizes that progress towards achieving compliance with the standards will differ from one service provider to another, both in terms of rate of progress and substance. During contract negotiations, each service provider is expected to set time specific goals for their organization's progress towards compliance with the standards in the form of a work plan. This work plan may be revised by the provider throughout the year with the prior written approval of the County. Revisions may be requested only if circumstances outside the provider's control impede its ability to achieve compliance with the standards by the target dates indicated in the originally approved work plan.

No Barriers to Service

Standard #1

Client access to services, system wide, shall be facilitated and barriers to service eliminated.

Guidelines	Indicator	Data Source
(1.1 – 1.5) Providers shall eliminate barriers to service caused by: (A) hours of operation (B) language and culture (C) lagtime. *Exemptions: (A) All services not specified (B) None (C) 1.5 None; (C) 1.6 Prescription Drugs, Case Management, MAI Case Management*	**A: Hours of Service:**	
	1.1 Medical care, pharmaceuticals, case management and home health care shall provide a minimum of 40 hours access to services per week including 4 hours after 6 P.M. weeknights and 4 hours on weekends	➢ Scope of Service Description ➢ Posted hours of service
	1.2 24-hour on-call access to pharmaceutical services, emergency medical care, home health care and crisis counseling	➢ Scope of Service Description ➢ Posted hours of service
	B: Language:	
	1.3 When 20% of clients prefer another language or require special assistance, such as illiteracy, native language speakers, translators or special assistance shall be made available as appropriate	➢ Record Review ➢ Personnel Files ➢ Observation ➢ Written Policies and Procedures ➢ Invoices (reviewed during on-site visit)
	1.4 Interpreters for hearing impaired and special assistance for those requiring such (as visually impaired persons) shall be made available	➢ Observation ➢ Personnel Files ➢ Record Review
	1.5 Cultural sensitivity and linguistic competency are demonstrated as a component of care for target populations	➢ Observation ➢ Personnel Files ➢ Record Review

Guidelines	Indicator	Data Source
	C: Lagtime: 1.6 80% of clients will see a direct service worker no later than 5 workdays from the client's initial date of contact or date of case management referral 1.7 80% of clients initially presenting at a non-case management agency shall be referred to a case management agency no later than 2 workdays from the date of initial contact with the referring agency	➢ Record Review • Intake information including date of initial contact or copy of referral • SDIS referral report

Staff Qualifications/Training

Standard #2

Agencies shall ensure that all staff have sufficient education, knowledge, skills and experience to competently serve the HIV/AIDS client population: agencies must provide initial orientation and training for new staff and ensure all staff participate in ongoing HIV/AIDS trainings, thereby promoting provision of high quality, up-to-date services.

Guidelines	Indicator	Data Source
(2.1 – 2.2) Supervisory staff and direct service staff shall meet the qualifications of education and experience required by the Miami-Dade County Office of Management and Budget and the Miami-Dade HIV/AIDS Partnership. *Exemptions: 2.1 None: 2.2 Grocery Vouchers; Home Delivered Meals, Food Bank, Utility Assistance, Transportation Vouchers, Prescription Drugs, Case Management (Refer to Case Management Standards for education/experience requirements).*	2.1 80% minimum of direct service supervisors are licensed and/or have a bachelor's degree in social sciences, counseling or nursing; have management experience; or have equivalent HIV/AIDS or related experience 2.2 80% minimum of direct service staff have an associate degree (AA) in social sciences, counseling or nursing. HIV/AIDS or related experience, including living with HIV, may be substituted on a year-for-year basis. Exempt personnel must be supervised by staff that meets minimum supervisory qualifications (2.1)	➢ Personnel Files • Copies of degrees/licenses • Documentation of work experience (letters of recommendation, work references, etc) ➢ Personnel Files • Copies of degrees/licenses • Documentation of work experience, HIV/AIDS experience (letters of recommendation, work references, training certificates, etc) • Personnel Records

Guidelines	Indicator	Data Source
(2.3) Initial orientation and training shall be given to new staff. *Exemptions: None*	2.3 Documentation of initial orientation and training including Ryan White Title I services, standards and requirements	➢ Personnel Files • Signed, dated orientation schedule or Orientation Attendance Log • Signed, dated Ryan White Title I standards or form acknowledging training/receipt of same • Signed, dated job description
(2.4) Staff members will have a clear understanding of their job definition and responsibilities. *Exemptions: None*	2.4 Written job description including responsibilities	
(2.5 – 2.6) Policies and procedures for service provision shall be in written form and made available to all staff. *Exemptions: None*	2.5 Written Policies and Procedures (P & P's)	➢ Administrative Policies and Procedures
	2.6 Documentation that staff have read and are familiar with P & P's	➢ Personnel Records • Signed, dated agency policies and procedures • Signed, dated letter documenting P&P review, understanding
(2.7) Training in OSHA and universal precautions appropriate to job duties is provided and staff adheres to these principles. *Exemptions: None*	2.7 Documentation of training	➢ Signed, dated training acknowledgement, attendance logs with dates and subject matter of training, agency training logs
(2.8) Direct service staff are knowledgeable about Ryan White Title I standards and service requirements. *Exemptions: None*	2.8 Annual update on Ryan White Title I standards and service requirements	➢ Signed, dated Ryan White Title I standards or form acknowledging receipt/training on same
(2.9) Staff shall remain updated on HIV/AIDS information. *Exemptions: None*	2.9 At least once annually: direct service staff shall attend an HIV/AIDS seminar/training appropriate to their level of service delivery	➢ Personnel Records • Proof of attendance, certificate or other documentation including training subject matter, date(s) of attendance, hours in training ➢ Agency training record

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Guidelines	Indicator	Data Source
(2.10) Personnel working with children are to be screened in accordance with state or local laws. *Exemptions: None*	2.10 Clearance letters for abuse and criminal screening	➢ Personnel files

Documentation Standards
Standard #3
Standardized forms and consistent up-to-date protocols will be utilized across the system to ensure uniform quality of care.

Guidelines	Indicator	Data Source
(3.1 – 3.11) Documentation for intake and service provision shall include, at a minimum, standard forms and required client data. The treatment or care plan shall be unique for each client, culturally sensitive, non-judgmental, personalized and with an appropriate standard of care with respect to a person's right to privacy. *Exemptions :Pharmaceuticals, Grocery Vouchers, Transportation Vouchers, Utility Assistance, Outreach Services, Food Bank*	Record contains: 3.1 Financial assessment and proof of HIV OR a Ryan White Title I Certified Referral 3.2 Consent for enrollment/treatment OR a Ryan White Title I Certified Referral 3.3 Consent to Release and Exchange Information (SDIS) OR a Ryan White Title I Certified Referral 3.4 Intake history (Client demographics and personal contact information) 3.5 Documentation client confidentiality explained 3.6 Documentation grievance procedure explained 3.7 Documentation choice of providers explained 3.8 Service provision history 3.9 Treatment/Service Plan documenting reason(s) for treatment, process and progress, outcomes of treatment 3.10 Eligibility screening for third party payers 3.11 Treatment/Service Plan update at least once per year *Note: Case managers are required to update Title I Certified Referrals (Recertification) every 6 months.*	➢ Record Review • All required forms are complete, initialed, dated, signed as appropriate • Copies of required eligibility documents are present, current (within 6 months), and legible • Documentation of eligibility screening for third party payers is present • Cases are closed as appropriate

Guidelines	Indicator	Data Source
(3.12 – 3.15) Referrals: Providers will maintain adequate documentation on referral activities. *Exemptions: None*	3.12 Inbound referrals for all Title I Certified Referrals, shall record origin of referral and service requested 3.13 Outbound referrals for all Title I Certified Referrals shall record the referral destination and service requested 3.14 All inbound referrals filed in client record 3.15 Service referrals not initiated by a case manager shall be documented in a progress note or treatment plan	➢ SDIS Referral Report ➢ Record Review
(3.16 – 3.18) Providers will avail themselves of all available resources to provide needed services to HIV/AIDS clients including the Ryan White service network, key points of service entry, city, state and private organizations. *Exemptions: None*	3.16 Linkage agreements 3.17 Service resources 3.18 Inbound, Outbound Referrals	➢ Administrative Records ➢ Lists of Service Resources ➢ SDIS Referral Report

Quality Assurance/Performance Improvement

Standard #4

Ongoing quality assurance activities with regular feedback to staff promote performance improvement and quality care.

Guidelines	Indicator	Data Source
(4.1 – 4.4) Supervisory record reviews are conducted regularly, with feedback to direct care staff resulting in improved performance. *Exemptions: None*	4.1 Record reviews conducted quarterly 4.2 No less than 40 records or 10% of Ryan White Title I population (whichever is less) 4.3 Evidence of feedback between supervisor and employee 4.4 Documentation review ensures Ryan White eligibility standards are met and that case notes are appropriate, timely and legible	➢ Supervisor's Records • Documentation of reviews with identifying client information • Documentation of employee feedback ➢ Record Review

Guidelines	Indicator	Data Source
(4.5) Medical Services: Quality assurance or patient care review meetings will identify problems to be resolved through action. *Exemptions: None*	4.5 Documentation of quarterly patient care reviews or quality assurance meetings recording attendance, date, subject matter, steps taken to resolve identified problems with time frames for resolution.	➢ Meeting minutes ➢ Attendance logs
(4.6) Non-Medical Services: Quality improvement issues will be addressed through staff meetings. *Exemptions: None*	4.6 Documentation of quarterly quality improvement meetings recording attendance, date, subject matter, steps taken to resolve identified problems with times frames for resolution.	➢ Meeting minutes ➢ Attendance logs
(4.7 – 4.8) Annual client satisfaction survey conducted and results utilized as appropriate to improve service delivery. *Exemptions: None*	4.7 Client satisfaction survey to include: Rating of services, perception of treatment by staff, satisfaction with services provided, fair access to services provided.	➢ Review of client satisfaction survey
	4.8 Written plans and objectives incorporate results as appropriate from client satisfaction surveys	➢ Client Satisfaction Survey ➢ Administrative records

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Confidentiality

Standard #5

Every agency shall provide staff with initial and ongoing training regarding client confidentiality to ensure client information is protected in accordance with state and federal laws.

Guidelines	Indicator	Data Source
(5.1 – 5.2) Every agency shall have a written Policy and Procedure (P & P) addressing confidentiality. *Exemptions: None*	5.1 Written P & P addressing HIV confidentiality and agency procedures, including policies and procedures that limit access to passwords, electronic files, medical records, faxes, release of client information	➢ Administrative P & P's

	5.2 P & P is signed and dated annually by staff	➢ Personnel files • Signed, dated copy of P & P for all staff
(5.3) Services shall be provided in a confidential setting. *Exemptions: None*	5.3 Areas in which client contact occurs allow exchange of confidential information in a private manner.	➢ Observation
(5.4) All hard copy materials and records shall be securely maintained.	5.4 Records, hard copy materials maintained under double lock in files and in areas secure from public access.	➢ Observation
(5.5) All clients shall be informed regarding their rights to confidentiality. *Exemptions: None*	5.5 Documentation signed and dated by client acknowledging client has been fully informed of his/her right to confidentiality.	➢ Record review
(5.6) No release of client information without a signed, dated client release. *Exemptions: None*	5.6 Signed, dated Release of Information* specific to HIV, TB, STD, substance abuse and mental health OR note reflecting client's unwillingness to sign a Release. * *This release shall be renewed annually.*	➢ Record Review

Program Operating Requirements (POR)

POR #1	Indicator	Data Source
(POR 1.1 – 1.4) Operating procedures affecting clients shall be posted publicly. *Exemptions: None*	The following shall be posted in an area to which clients have free access: POR 1.1 Hours of operation POR 1.2 Grievance procedures POR 1.3 Client's Bill of Rights and Responsibilities POR 1.4 Ryan White Title I Service Prices (cost per unit of service)	➢ Observation

POR #2	Indicator	Data Source
(POR 2.1) Manual or backup systems are kept current. *Exemptions: None*	POR 2.1 Manual or backup systems are updated at least weekly	➢ Record Review ➢ SDIS

POR #3	Indicator	Data Source
(POR 3.1– 3.4) Client participation and education in the treatment process shall be maximized. *Exemptions: None* (POR 3.5) Client education and knowledge lead to improved compliance, health status. *Exemptions: None*	Documentation shall reflect: POR 3.1 Client and family (as defined by client) participation in care decisions POR 3.2 Development of client's understanding of treatment options POR 3.3 Client empowerment POR 3.4 Monitoring of client adherence to prescribed plans of treatment and care including medication regimens POR 3.5 Documentation of client education and/or resources provided, as appropriate	➢ Record Review • Progress Notes • Treatment/Care Plans

POR: Facility/Operation

POR #4	Indicator	Data Source
(POR 4.1 – 4.6) All provider sites are safe and secure. *Exemptions: None*	POR 4.1 Site is clean and well-maintained, inside and out POR 4.2 Clients have untroubled access coming and going POR 4.3 Security personnel are available as needed	➢ Observation ➢ Personnel Records
	POR 4.4 Written policy to refuse service to clients who are being verbally abusive, threatening physical abuse or possessing illegal substances or weapons on provider property	➢ Administrative Policies and Procedures
	POR 4.5 Facility complies with applicable Occupational Safety and Health Administrative (OSHA) requirements	➢ Observation
	POR 4.6 Facility complies with the American's with Disability Act's programmatic and accessibility requirements	➢ Observation

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POR #5	Indicator	Data Source
(POR 5.1) Client access to care will be facilitated during regular hours and after hours (nights and weekends). *Exemptions:As noted in Standard 1.1*	POR 5.1 Written P & P addresses contacts (including appointments) during regular hours and walk-ins, emergency and after hours (nights, weekends and holidays) care.	➢ Administrative Policies and Procedures *(Refer to Standard #1.1)*

POR #6	Indicator	Data Source
(POR 6.1 – 6.2) Clients shall receive an explanation of the agency's grievance procedures and confirm their understanding of such. *Exemptions: None*	POR 6.1 Written P & P's addressing formal and informal grievance procedures for clients POR 6.2 Documentation that patient has had grievance procedures, formal and informal explained and/or given to him and understands same.	➢ Administrative Policies and Procedures ➢ Record Review

POR #7	Indicator	Data Source
(POR 7.1 – 7.2) Agency policies are known to staff and supervisors. *Exemptions: None*	POR 7.1 Written P & P's addressing agency procedures including a formal grievance procedure for staff. POR 7.2 Documented acknowledgement that staff are familiar with written P & P's, including grievance procedures.	➢ Administrative Policies and Procedures ➢ Personnel Records

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POR: Accreditation Standards

POR #8	Indicator	Data Source
(POR 8.1) Agency complies with appropriate professional licensing in accordance with professional training and responsibilities of caregivers, the agency's functions, or both, through national associations and/or the Florida Department of	POR 8.1 Current licenses, accreditations are Posted and on file	➢ Administrative Records ➢ Observation

Health. *Exemptions: None* (POR 8.2) Staff are licensed as specified in the Title I Service Descriptions. *Exemptions: None*	POR 8.2 Copies of current licenses are on file	➢ Personnel Records

POR: Patient Acknowledgement of Services Received

POR #9	Indicator	Data Source
(POR 9.1) Patient acknowledgement of service(s) received shall be maintained.	POR 9.1 Patient shall acknowledge by signature and date, specified services received at each visit. Required information includes patient name, date of service, definition of unit, service provided, number of units.	➢ Record Review • Signed, dated logs with name and services received noted OR ➢ Billing Review • Signed, dated encounters or superbills with name and services received noted OR • Receipt given to client with a copy in the chart *(Refer to POR #1.4)*

POR: Service Delivery Information System (SDIS)

POR # 10	Indicator	Data Source
(POR 10.1 – 10.2) Timely entry into the SDIS of new client information, updated client information and services provided. *Exemptions: None*	POR 10.1 New client information shall be entered at intake POR 10.2 Updated client information and service information shall be entered in accordance with time specifications detailed in the current Title I Ryan White contract	➢ Record Review ➢ SDIS

POR #11	Indicator	Data Source
(POR 11.1) A record (client chart) shall be maintained for each individual client	POR 11.1 An individual record (chart) shall be maintained for each client that records the services provided by Ryan White Title I.	➢ Record Review

MIAMI-DADE COUNTY
RYAN WHITE TITLE I PROGRAM

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COORDINATED CASE MANAGEMENT
STANDARDS OF SERVICE

Effective August 12, 2002

RFP No. RW1401
ATTACHMENT 26

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MIAMI-DADE COUNTY
RYAN WHITE TITLE I PROGRAM
COORDINATED CASE MANAGEMENT STANDARDS OF SERVICE

In addition to the System-wide Standards of Care applicable to all Title I providers, the following program specific standards apply to **case management providers only**. These standards are an essential component of the Ryan White Title I quality management program and form the basis on-going monitoring and evaluation of Title I funded case management providers by the Miami-Dade County Office of Management and Budget and/or its authorized representatives.

With the exception of staff qualifications *(Standard #1)*, it is not expected that contracted organizations be in full compliance with the Case Management Standards of Service at the time of contract execution. It is assumed, however, that the service provider has read and understands the standards, and by signing a contract the provider is agreeing to make every effort to progress towards full compliance with these standards. The County recognizes that progress towards achieving compliance with the standards will differ from one service provider to another, both in terms of rate of progress and substance. During contract negotiations, each case management provider is expected to set time specific goals for their organization's progress towards compliance with the standards in the form of a work plan. This work plan may be revised by the provider throughout the year with the prior written approval of the County. Revisions may be requested only if circumstances outside the provider's control impede its ability to achieve compliance with the standards by the target dates indicated in the originally approved work plan.

Case management is a range of client-centered services that links clients with health care, psychosocial and other services to insure timely, coordinated access to medically appropriate levels of health and support services, continuity of care, ongoing assessment of the client's needs, personal support systems, and case management services that prevent unnecessary hospitalization or that expedite discharge, as medically appropriate.

Case management is a client-centered collaborative process that meets an individual's health and support service needs by assessing, planning, implementing, coordinating, monitoring and evaluating available options and services. Case management addresses situational needs and promotes continuity of care for the client. Case management is predicated upon patient empowerment, realized through the identification of client needs and subsequent facilitation of access to appropriate services.

The purpose and goals of case management are: 1) to coordinate services across funding streams; 2) to reduce service duplication across providers; 3) to assist the client with accessing services; 4) to use available funds and services in the most efficient and effective manner; 5) to increase the client's adherence to the care plan (i.e., medication regimen) through counseling; 6) to empower clients to remain as independent as possible; 7) to improve service outcomes; and 8) to control cost while ensuring that the client's needs are properly addressed.

Staff Qualifications

Standard #1

All case management supervisors, case managers and peer counselors shall have sufficient education, knowledge, skills and experience to competently serve the HIV/AIDS client population.

Guidelines	Indicators	Data Source
(1.1 – 1.8) All supervisors, case managers and peer counselors must meet the qualifications of education and experience required by the Miami-Dade County Office of Management and Budget and the Miami-Dade HIV/AIDS Partnership.	Supervisors: 1.1 Master's degree OR Bachelor's degree with 5 years work experience in HIV/AIDS. 1.2 HIV/AIDS and supervisory experience preferred. Case Managers:* 1.3 Bachelor's degree in a social science area , OR Bachelor's of Science in Nursing (BSN) degree with 6 months of case management experience, OR Bachelor's degree not in a social science with 1 year of case management experience. 1.4 Knowledge of HIV/AIDS disease and the Miami-Dade HIV/AIDS service delivery system preferred 1.5 Completion of a proficiency test based on required system-wide training within 12 mos. of hire * *An individual in a case management position prior to the effective date of these standards may substitute applicable experience on a year-to-year basis for the required education.* Peer Counselors 1.6 High school degree 1.7 1 year's experience in HIV/AIDS services 1.8 Training on HIV funding streams	➢ Personnel files • Copies of degrees • Documentation, validation of work experience (for example, letter from former employer or documented telephone interview with former employer) • Copies of degrees • Documentation, validation of work experience (for example, letter from former employer or documented telephone interview with former employer) • Proof of knowledge on funding streams • Training Certificate • Copy of degree • Documentation of HIV/AIDS service system experience (letters of reference, documented telephone interview) • Proof of training on funding streams

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Training

Standard #2

To ensure the highest level of case management service, supervisors, case managers and peer counselors, through initial and ongoing monthly trainings, shall be continuously updated on changes in HIV/AIDS health care, the community-wide service system (services and limitations), community resources, local, state and federal programs in the area.

Guidelines	Indicators	Data Source
(2.1 – 2.5) Case management supervisors, case managers and peer counselors shall comply with all training requirements mandated and approved by the Miami-Dade County Office of Management and Budget and the Miami-Dade HIV/AIDS Partnership.	Case management supervisors, case managers and peer counselors shall complete: 2.1 HIV/AIDS 104[1] within 1 month of hire 2.2 HIV/AIDS 500[1] and 501[1,2] within 6 months of hire	➢ Personnel files • 104 Certificate dated within 1 month of hire • 500 Certificate dated within 6 months of hire • 501 Certificate dated within 6 months of hire
	2.3 Case management supervisors: 40 hours of CEU-type annual training approved by the County with 20 of the 40 hours in management training	• Proof of attendance, certificate or other documentation including training subject matter, date(s) of attendance, hours in training.
	2.4 Case managers and peer counselors: 40 hours annually of monthly system-wide case management related training approved by the County	• Agency training record • Case management system- wide attendance logs
	2.5 In addition to the training hours in 2.4, case managers and peer counselors in the Ryan White Title I System less than 2 yrs: 20 hours of basic case management training[1]	• Training Certificate
(2.6) Case managers and peer counselors shall maintain all updated materials and lists of resources provided at trainings.	2.6 Provider/service listings, updated Ryan White Title I Case Management Handbook, other training materials as appropriate	• Training agendas • On-site inspection/observation

[1] *104, 500, 501 and basic case management training are not part of the 40-hour system-wide training requirement (item 2.4).*

[2] *If counseling and testing are part of the case manager's job duties, an annual 501 update is required.*

No Barriers to Service

Standard #3

Client access to case management and peer counseling services shall be facilitated in a timely and orderly manner.

Guidelines	Indicators	Data Source
(3.1 – 3.2) Initial intake and financial eligibility assessment initiated.	No later than 2 workdays from a request for service or receipt of referral: 3.1 Appointment made for intake/financial eligibility assessment 3.2 Case manager assigned	➢ Record review • Intake/financial eligibility forms dated within 5 days of filed referral or date of service request AND • Intake progress note reflects: Date of referral or service request and date of intake/financial eligibility assessment • Record reflects name of assigned case manager and date of assignment
(3.3) If client wishes to meet with a peer counselor, an appointment is facilitated.	3.3 Meeting will take place no later than 24 hours from the date of request for service or receipt of referral.	➢ Record review • Dated progress note reflects date of referral OR date of request for service AND service rendered or refused per progress note from peer counselor documenting appointment completed or appointment declined. *(See Standards #4 and #5)*

Eligibility and Financial Assessment *

Standard #4

A comprehensive eligibility and financial assessment shall be completed taking into account all funding streams and services for which the client may qualify: the client's education and orientation to the service delivery system and to client rights and responsibilities shall be initiated.

Guidelines	Indicators	Data Source
(4.1 – 4.10) Eligibility and financial assessment shall ensure all required documents are present and filed in the eligibility section of the record. Clients shall be informed of their right to: confidentiality in accordance with state and federal laws, choice of providers, explanation of grievance procedures, Client Bill of Rights and Responsibilities.	No later than 5 workdays from receipt of referral or date of request for service, the following shall be completed: 4.1 Client Chart/Record Face Sheet 4.2 Composite Consent (includes Client Bill of Rights and Responsibilities) 4.3 Consent to Release and Exchange Information (SDIS) 4.4 Proof of HIV 4.5 Proof of Income 4.6 Financial Assessment 4.7 Proof of Miami-Dade County residency 4.8 Picture ID 4.9 Social Security (if client has SS Number) 4.10 Eligibility screening for third party payers	➢ Record review • All required forms are complete, initialed, dated, signed as appropriate. • Copies of required eligibility documents are present and legible. • Documentation of eligibility screening for third party payers is present. *(See Standard #11, 11.1 – 11.4)*

* *Eligibility and financial assessment need not be done by a case manager. This function may be performed by a trained eligibility clerk or a peer counselor with the appropriate training to conduct financial assessment and eligibility screening.*

Initial Client Assessment and Plan of Care

Standard #5

The case manager shall develop a comprehensive and individualized Needs Assessment and Plan of Care: orientation and education in the service delivery system shall continue: the client shall be assisted to access timely, appropriate services: medication adherence shall be reinforced and medical information necessary to appropriately serve the client shall be obtained.

Guidelines	Indicators	Data Source
(5.1 – 5.3) An initial comprehensive assessment and plan of care shall be completed for all case management clients to include: Adherence assessment with appropriate client referrals to existing adherence programs as part of the POC. Referrals to the University of Miami for pregnant women shall be made within 24 hours of initial contact with the case manager. (5.4 – 5.8) All referrals shall be documented in the POC. *(Applies to the referring agency.)*	No later than 5 workdays from completion of the eligibility/financial assessment the case manager shall complete: 5.1 Initial Comprehensive Assessment 5.2 Initial Plan of Care (POC) 5.3 Referrals Referrals documented in the POC will include: 5.4 Date and purpose of referral 5.5 Frequency of the requested service (how often the requested service is needed) 5.6 Provider of the requested service (agency receiving the referral) 5.7 Date of appointment 5.8 Date of follow up	➢ Record review ➢ SDIS review • Completed, dated, signed (case manager and client) comprehensive assessment • Completed, dated, signed (case manager and client) POC based on needs identified in the comprehensive assessment • SDIS Referral Report *(See Standards# 6, 6.2 – 6.9; 11, 11.1 – 11.4)*
(5.9) The client will be scheduled to meet with a peer counselor, unless the client refuses and the refusal is documented.	5.9 Progress note reflecting date of appointment with a peer counselor or documentation an appointment was refused.	➢ Record review • Progress notes

Guidelines	Indicators	Data Source
(5.10 – 5.11) Case managers shall ensure all required medical data is complete, legible, dated, filed in the appropriate section of the client record and entered into the SDIS.	5.10 Medical Certification of Diagnosis The case manager shall obtain Medical Certification of Diagnosis within 30 days of completion of the initial POC. The form shall be filed in the client record and the information entered into SDIS within 24 hrs of availability. 5.11 Quarterly/Annual Lab Results The case manager shall obtain initial (using Quarterly/Annual Lab Results Form) quarterly labs within 30 days of completion of the initial POC: the form shall be filed in the client record and the information entered into the SDIS within 24 hrs. of availability.	➢ Record review ➢ SDIS review ➢ Record review ➢ SDIS review
(5.12) Applications for eligibility under entitlement and benefit programs must be completed and filed with the appropriate entities.	5.12 Within 45 days of completion of eligibility and financial screening: dated, signed copies of applications, referral and progress note reflecting screening and submission of forms.	➢ Record review • POC • Progress notes • SDIS
(5.13) A progress note shall document the needs assessment and POC.	5.13 Dated, signed progress note corresponding to completion date of POC	➢ Record review • POC • Progress notes

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Referrals/Follow-Up

Standard #6

Case managers and Peer Educators shall follow-up to verify clients are receiving necessary services as documented in the Plan of Care and coordinate their efforts with other service providers to ensure service delivery is as seamless and unobtrusive as possible to the client. The client's satisfaction with services received shall be assessed.

Guidelines	Indicators	Data Source
(6.1) The peer counselor shall follow-up, either face to face or by telephone, within 2 weeks of his/her initial meeting with a newly enrolled client.	6.1 Dated, signed progress note	➢ Record review
(6.2 – 6.4) Certified referrals between Ryan White Title I providers shall be generated electronically through the SDIS using the Certified Ryan White Title I Referral Form and recertified as needed every 6 months.	6.2 POC 6.3 SDIS 6.4 Progress notes	➢ Record review ➢ SDIS review ➢ Record Review *(See Standard #5, 5.4 – 5.8)*
(6.5 – 6.6) Referrals to providers outside the Ryan White Title I provider network shall be printed out from the SDIS using the General Referral Form.	6.5 POC 6.6 SDIS	➢ Record review ➢ SDIS review
(6.7) Medication referrals shall note the name of the medication, dosage, strength and quantity.	6.7 POC	➢ Record review • POC
(6.8 – 6.9) Referral follow up for medications and other services shall be done in a timely way to ensure coordination and benefit of service. All follow -up shall be documented in the progress notes.	Progress notes shall reflect: 6.8 Medication referrals followed-up no later than 5 workdays from the referral date	➢ Record review • Progress notes
	6.9 Referrals for other services followed-up no later than 5 days from the appointment date or service delivery date.	➢ Record review • Progress notes
(6.10) All follow up on referrals shall assess the client's satisfaction with the service.	6.10 Client satisfaction, or lack thereof, documented in progress note.	➢ Record review • Progress notes

Updates to Client Record

Standard #7

Appropriate client contact shall be maintained as needed to monitor the client's personal/medical status and the efficacy of the Plan of Care (POC) shall be assessed to ensure service needs, goals, objectives and barriers as noted in the POC are addressed.

Guidelines	Indicators	Data Source
(7.1) An update (client contact) shall be documented no less than once every 3 months, or more often as client need may dictate per documentation.	7.1 Dated, signed progress note documenting client contact and adherence monitoring.	➢ Record review • Progress notes
(7.2 – 7.3) Client medical care and compliance shall be monitored to ensure optimal health results.	7.2 Quarterly/Annual Lab Results updated every quarter with CD4 and VL entered in SDIS within 24 hours of availability. 7.3 Annual medical data entered in SDIS prior to end of the calendar year.	• Quarterly/Annual Lab Results • SDIS
(7.4 – 7.9) Financial eligibility, client chart/record face sheet, needs assessments and plans of care shall be updated no less than once every 6 months, more often as client need may dictate per documentation. The Medical Certification of Diagnosis for non-AIDS patients shall be updated every 6 months.	Dated and signed as appropriate: 7.4 Client Chart/Record Face Sheet 7.5 Financial assessments 7.6 Needs Assessments and Plans of Care 7.7 Medical Certification of Diagnosis 7.8 Progress notes 7.9 Quarterly/Annual Lab Results	➢ Record review ➢ SDIS review • Updated forms • Progress notes reflecting update and noting Medical Certification of Diagnosis has been addressed
(7.10) The Composite Consent for Enrollment shall be renewed annually. Client must sign and date the Composite Consent Form annually.	7.10 Dated, signed Composite Consent Form	➢ Record review

Documentation Standards

Standard #8

To ensure consistency and quality of care across the case management service system, standardized forms shall be used and uniform standards of documentation shall be followed.

Guidelines	Indicators	Data Source
(8.1) Standardized forms shall be used.	8.1 Required SDIS forms are complete, dated and signed as necessary, and filed in the client record.	➢ Record review ➢ SDIS review • SDIS printouts
(8.2 – 8.3) Agencies shall have available in 3 languages: Composite Consent for Enrollment (includes the Client Bill of Rights and Responsibilities), Consent to Release and Exchange Information in the SDIS	8.2 Signed, dated Composite Consents 8.3 Signed, dated Consents to Release and Exchange Information (SDIS)	➢ Record review
(8.4) All client contacts shall be documented in the progress notes no later than 24 hours after occurrence.	8.4 Dated, signed progress notes	➢ Record review
(8.5) All peer counseling and case management units of service billed to Ryan White Title I shall be documented in the client chart.	8.5 Dated, signed progress notes	➢ Record review • Progress notes • Reimbursement requests
(8.6) Documentation shall accurately record the time services began and ended and number of service units provided (15 minute encounters).	8.6 Dated, signed progress notes documenting time and units, e.g. 11:30 AM to 11:58 AM, 2 units	➢ Record review • Progress notes • Reimbursement requests
(8.7) All documentation shall be complete and legible, dated, signed and include the name and title of the individual making the entry.	8.7 All required forms and progress notes	➢ Record review • Progress notes • Forms

Quality Assurance/Performance Improvement

Standard #9

Ongoing, systematic record reviews shall be performed with feedback provided to case managers resulting in continuously improving quality of service and performance.

Guidelines	Indicators	Data Source
(9.1 – 9.4) Case management supervisors shall implement and document ongoing record reviews as part of quality assurance and performance improvement activity. Review tools will be dated and signed by the supervisor.	9.1 Record reviews conducted quarterly 9.2 No less than 40 records or 10% of Ryan White Title I population reviewed (whichever is less) 9.3 Review documents information is entered in a timely fashion, is complete, legible and appropriate 9.4 Dated, signed review tools including client identification information	➢ Record review • Review of client records • Review of supervisor's reviews
(9.5 – 9.6) Quarterly patient care review and/or quality improvement meetings shall be documented.	9.5 Meeting attendance logs 9.6 Meeting minutes reflect issues discussed, problems identified, actions for correction and a time frame for completion of same	➢ Attendance logs ➢ Minutes

Standard #10

The case manager shall carry a reasonable case load that allows the case manager to effectively plan, provide and evaluate tasks related to client and system interventions.

Guidelines	Indicator	Data Source
(10.1 – 10.2) Case loads shall be reviewed between the supervisor and case manager to determine and document caseload size.	10.1 Case review at least every 6 months 10.2 Active case load not to exceed 70 clients, not including occasional clients	➢ SDIS • Case load (print out of active case load per case manager) ➢ Administrative • Supervisory logs or records documenting case review • Case load lists (case managers)

Service Delivery Information System (SDIS)

Standard #11

Service access for clients, data collection and reporting requirements shall be facilitated by requiring all pertinent client data be entered into the SDIS in a timely manner.

Refer to Standards #4, #5, #6, #7, #8, #9, #10, and #13.

Guidelines	Indicators	Data Source
(11.1) All Ryan White Title I intake information shall be entered into the SDIS in a timely manner.	11.1 Ryan White Title I Intake information entered into the SDIS at time of initial contact.	➢ Record review ➢ SDIS review
(11.2 – 11.4) Financial eligibility, needs assessment and POC information shall be completed and entered into SDIS.	11.2 Financial eligibility, needs assessments and POCs entered into the SDIS within 24 hours of completion. 11.3 Dated, signed eligibility, assessment and POC 11.4 SDIS print outs	➢ Record review ➢ SDIS review

Permanency Planning

Standard #12

The client shall be assisted in developing a legally binding plan for care of dependents, disposition of assets and other pertinent issues in the event of personal incapacitation.

Guidelines	Indicators	Data Source
(12.1 – 12.4) No later than one year from the date of the initial POC completion, the case manager will refer clients to a legal service provider for permanency planning or document that the patient refused said service.	12.1 Plan of Care reflects referral within 1 year from initial POC 12.2 SDIS reflects referral 12.3 Permanency plan addresses care of dependents, disposition of assets, other pertinent issues. 12.4 Progress note or POC reflects patient declined permanency planning.	➢ Record review ➢ SDIS review • Needs Assessment • Plan of Care • Progress Notes • Permanency Plan • SDIS Referral Report

Standard #13

Client records shall be closed with a case closure form; clients who wish to transfer shall be enabled to do so in a timely manner.

Guidelines	Indicators	Data Source
(13.1) Client records shall be closed with a Case Closure or Case Transfer Form.	Client records shall include: 13.1 A Case Closure Form detailing the reasons for closure.	➢ Record review ➢ SDIS review • Progress notes • Case Closure Form • Case Transfer Form • Outgoing record log • Current (at time of request) Consent to Release Information
(13.2 – 13.4) Clients who wish to transfer shall be assisted to do so.	Copies of client records for transfers shall be mailed: 13.2 No later than 10 days from the date of the receipt of a written request from the client or the client's legal representative. 13.3 Prior to releasing information a current Consent to Release Information must be in the record. 13.4 A completed Transfer Form.	
(13.5) Closure information shall contain an address/phone number/emergency contact where the client may be reached or detail the reason why said information cannot be obtained.	13.5 Completed Case Closure or Case Transfer Form	➢ Record Review
(13.6) Case closures and transfers shall be entered into the SDIS.	No later than 24 hours after completing a closure or transfer: 13.6 Data in SDIS	➢ Record review ➢ SDIS review • Closure or Transfer Form

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Program Specific Operating Requirements (PS)

Standard #PS 1

Standard	Indicators	Data Source
Case management providers must offer both case management and peer education support network services.	PS1.1 Progress notes PS1.2 Reimbursement requests	➢ Personnel files ➢ Record review ➢ SDIS

Standard #PS 2

Standard	Indicators	Data Source
Case management providers must have trilingual capabilities.	PS2.1 Progress notes PS2.2 Staff interviews	➢Record review ➢ Personnel files ➢ Observation

Standard #PS 3

Standard	Indicators	Data Source
Case management agencies must document they have sought enrollment in PAC Waiver within 30 days of the contract execution date.	PS3.1 Copy of completed, dated application PS3.2 PAC Waiver number(s)	➢Agency records

Standard #PS 4

Standard	Indicators	Data Source
Case management agencies shall ensure clients are aware of their rights and responsibilities.	PS4.1 Copy of the Client Rights and Responsibilities posted in a public area.	➢ Observation

Standard #PS 5

Standard	Indicators	Data Source
Case management providers shall ensure the provision of interpreters/assistance to the hearing and reading impaired.	PS 5.1 Providers shall allocate funds in their budgets to ensure provision of interpreters/assistance to the hearing and reading impaired.	➢ Budget review ➢ Invoices

Standard #PS 6

Standard	Indicators	Data Source
Providers shall ensure continuity and coordination of care across services.	PS 6.1 Providers shall maintain linkage agreements with other service providers throughout the community.	➢ Administrative Review ➢ Linkage Agreements

Miami-Dade County Ryan White Title I Program

Minimum Primary Medical Care Standards
For Chart Review

Medical Care Subcommittee
Miami-Dade HIV/AIDS Partnership

Statement of Intent: All Ryan White Title I funded physicians are required by contract to adhere to the PHS Guidelines.

Requirements for Practitioners (M.D., D.O., ARNP, PA)

- Maintain current and valid MD, DO, PA or NP State of Florida license
- Strongly encouraged to complete at least 30 hours of HIV-related CME Category 1 credits within a period of two years. New physicians and mid-level practitioners, if they are working with a physician meeting the standards, are encouraged to comply within one year.
- In compliance with the latest DHHS Guidelines
- Record reviews based on the standards

Minimum Standards Against Which Practitioners Will Be Measured

Assessments and Referrals

1. Comprehensive History and Physical (including breast exam for women) done or updated in past year

2. Vital signs, including weight, at least quarterly

3. Gyn exam including Pap and pelvic, initially once every 6 months until two negative, then once annually (women only)

4. RPR/VDRL screening for Syphilis annually

5. GC and Chlamydia annually for sexually active females

6. Assess annually and document education on:

    - Oral health care
    - Nutritional assessment/care

- Mental Health assessment/care
- Substance abuse assessment/care
- Domestic violence
- Adherence to medications
- Risk reduction (including safe sex practices)

7. PPD skin test performed and read annually

8. If PPD positive or *had active TB* were they treated or referred for treatment

Laboratory

9. CBC, CD4 and Viral Load every six months*
   **ADAP enrollment and re-enrollment requires CD4 and VL not > 4 months old.*

10. Electrolytes, BUN, Glucose, Creatinin, liver function tests, albumin, total protein, LDH, Lipid Profile

11. At initial screening, Hepatitis A baseline

12. Hepatitis B baseline serology

13. Hepatitis C baseline serology

Therapy/Interventions

14. Influenza vaccine offered annually

15. Pneumovax offered initially and at 6 years

16. Evaluate for risk of Hepatitis A and Hepatitis B and make appropriate intervention. Hepatitis A vaccine to high-risk groups, MSM, chronic Hepatitis B or C, travelers to endemic areas. Give Hepatitis B series once.

17. Documentation that tetanus/Diphtheria is up to date every 10 years.

18. HAART is considered and discussed. If offered, the risks and benefits are discussed.

19. On PCP prophylaxis per DHHS Guidelines

20. On MAC prophylaxis per DHHS Guidelines

21. On toxo prophylaxis DHHS Guidelines

22. Documentation:
    - Problem list
    - Medications list
    - Allergies list
    - Immunization list

OUTCOME MEASURES

OUTCOMES 2003
MIAMI-DADE COUNTY RYAN WHITE TITLE I

OUTPATIENT MEDICAL CARE

Outcomes	Indicators	Data Elements	Data Sources/Methods
Slowing/prevention of disease progression	Improved or maintained average CD4 counts, viral loads for clients as measured over a specified time period	Test results needed to calculate changes in CD4 counts, viral loads for individual clients over a specified time period	Upload of test data from outpatient medical care providers to SDIS on a quarterly basis
Reduced number or rate of AIDS-related hospitalizations	Change in the rate of AIDS-related hospitalizations over a specified period of time	Number of clients having AIDS-related hospitalizations, and the total number and days of AIDS-related hospitalizations for all clients during the specified time period	Disease Management AIDS algorithm applied to hospital data
Reduced incidence of AIDS-defining opportunistic conditions	Change in frequency of occurrence of AIDS-defining opportunistic conditions among clients over a specified time period	Number of cases of AIDS-defining opportunistic conditions, incidence of preventable conditions (e.g., PCP, MAC) among individual CARE Act clients over a specified period	AIDS Surveillance Data
Increased satisfaction of clients receiving outpatient medical care services	Change in the number of clients who receive outpatient medical care and report a service satisfaction level of good or better	Number and percent of HIV+ clients who receive outpatient medical care and report an overall rating of good or better for outpatient medical care services	Client survey

OUTCOME MEASURES

MIAMI-DADE COUNTY RYAN WHITE TITLE I

PRESCRIPTION DRUGS

Outcome:

1) Unduplicated number of clients who receive each type of prescription drugs (see below) and the number of drugs dispensed during the contract period:

- Prophylactic medications excluding nutritional supplements
- Nutritional supplements
- Antiretrovirals
- Protease Inhibitors
- Medications for Treatment of Infections/Conditions
- Antibiotics
- Pain Medications
- Other (specify)

OUTCOME MEASURES

MIAMI-DADE COUNTY RYAN WHITE TITLE I
CASE MANAGEMENT

Outcomes	Indicators	Data Elements	Data Sources/Methods
Increased maintenance of primary care services	Change in the number/percent of case management clients maintaining primary care services (at least one physician visit within the past 6 months) as measured over a specified time period	Number of case management clients maintaining primary care as measured over a specified time period	SDIS service across sites review Quarterly report of follow up with client/provider Future SDIS data report
Timely access to primary care services	Change in the number/percent of new clients entering medical care within a set time frame as measured over a specified period of time	New clients have a medical visit within 2 weeks of initial case management intake	SDIS service across sites review Quarterly report Future SDIS data report Record reviews
Increased number of clients accessing primary health care services.	Change in the number of clients who accessed primary health care programs after a specified time period	Number and percent of HIV + clients who did not have primary health care and accessed primary health care during specified time periods	SDIS data report
Increased satisfaction of clients receiving case management services	Change in the number of clients who receive case management and report a service satisfaction level of good or better	Number and percent of HIV+ clients who receive case management and report an overall rating of good or better for case management services	Client survey

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CASE MANAGEMENT PROCESS MEASURES

Process Measure	Data Elements	Data Sources/Methods
Complete bio-psychosocial assessment in record		
Care plan and goals in record, signed and dated by client		
Unduplicated number of clients screened for and enrolled in or formally denied for benefit program (Medicaid (all), Medicare, VA, Food Stamps, WIC, HUD Section 8, and other services in the community		
Each case management client sees the case manager at least every six months		
Information is updated every six months		
Case Manager/client ratio during the contract period.		

OUTCOME MEASURES

MIAMI-DADE COUNTY RYAN WHITE TITLE I

SUBSTANCE ABUSE TREATMENT RESIDENTIAL CARE

Outcomes	Indicators	Data Elements	Data Sources/Methods
Improved access to Substance Abuse residential care	Reduction in the number/percent of empty/unfilled beds as measured over a specified time period	Average number of empty beds per SDIS weekly announcement measured over a specified time period	Residential substance abuse reports to SDIS of empty/unfilled beds on a weekly basis
Decreased incidence of return to treatment	Change in the number/percent of returns to treatment for clients completing continuum of care* over a specified period of time	Assessment for prior treatment before continuum of care begun and after continuum of care completed **3 mos. and 6 mos. follow up to determine client remains out of residential treatment and remains drug free	Future quarterly report Future upload/entry into SDIS SDIS across sites service review SDIS data analysis
Increased consistency of medical care	Change in number/percent of clients completing residential treatment and remaining in primary care service as measured over a specified time period	At least one primary care visit within 6 mos. of discharge	Follow up assessment with quarterly report SDIS services across sites review
Improved effectiveness of residential substance abuse treatment as evidenced by length of stay	Change in number/percent of clients completing residential substance abuse treatment	Minimum three (3) months of residential substance abuse completed	Future quarterly report SDIS data
Increase in the number of clients accessing outpatient treatment after completing residential treatment	Change in number/percent of clients entering outpatient substance abuse treatment after completing residential treatment	Clients complete 3 mos. of residential care and within 2 weeks enter outpatient substance abuse treatment	Future quarterly report SDIS data/referrals

OUTCOME MEASURES

MIAMI-DADE COUNTY RYAN WHITE TITLE I
OUTREACH

Outcome	Indicators	Data Elements	Data Sources/Methods	Benchmark/Target
Increased connection to care	1. Number/percentage of new clients (individuals who have never been enrolled in the Title I system of care) who were connected for the first time to either medical care, case management, or, if necessary, substance abuse treatment.	Of unduplicated client contacts, number and percentage of those contacts who are successfully connected to care per quarter.	SDIS	Providers are required to successfully connect to care no less than 3% of clients contacted.
Increased connection to care	2.Number/percentage of clients lost to followup (those who had not received primary care in the past 6 months) who were reconnected to either medical care, case management, or, if necessary, substance abuse treatment.	Of unduplicated client contacts, number and percentage within a quarter who are successfully reconnected with care.	SDIS	This measurement will provide a baseline for future establishment of benchmarks/targets.
Increased connection to care	3. Increased number of formal written linkage or referral agreements with identified key points of entry and/or with service providers.	Number of formal written linkage agreements, with identified key points of entry and/or service providers, using standard forms with OSBM minimum standards and language,	Administrative reviews	
Increased connection to care	4. Increased number of clients identified through key points of entry	Number of clients identified through key points of entry.	SDIS	

RFP No. RW1401
ATTACHMENT 29

Data Elements for Ryan White Title I Monthly Reimbursement Reports

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This information must be collected at the time of service provision and reported on a monthly basis as part of your organization's reimbursement request. Certain service categories require that this information be reported on specific reimbursement forms. At a minimum, the following data elements must be reported:

- Client's CIS number (assigned by the Title I Service Delivery Information System), SFAN number (if available), or unique agency assigned identification number in numerical order;
- Service recipient code indicating if the service was provided to an HIV/AIDS client or to a client's family member/significant other **(NOTE: Title I services may only be provided to individuals who are not HIV+ under certain circumstances. Please refer to the Ryan White Title I Service Definitions as listed in Section 2.0, Scope of Services for specific eligibility requirements and other program specifications)**;
- Service date in chronological order;
- Service code (CPT code if applicable) providing a descriptor for the type of service rendered;
- Total number of service units provided to a client (if applicable);
- Service cost, Medicare or Medicaid Rate (if applicable);
- Applied multiplier or dispensing fee (if applicable) indicating the service provider's actual costs incurred in the delivery of this service;
- Total cost for services provided to each client.

*** Ryan White Title I Reimbursement Forms will be provided by Miami-Dade County**

RYAN WHITE TITLE I
SERVICE DELIVERY INFORMATION SYSTEM (SDIS)
CLIENT LEVEL INTAKE INFORMATION

THE FOLLOWING IS AN EXCERPT OF SCREENS FROM THE SDIS INDICATING FIELDS WHICH ARE REQUIRED FOR THE PURPOSE OF CONDUCTING A TITLE I CLIENT INTAKE:

RYAN WHITE - CLIENT INTAKE FORM (SCREEN 1)

Service Provider> .....
Agency Location: .....
L/Name: _____ F/Name: _____ M/Init: _____

Intake Date: _____ New Client? ___ Follow-Up Client? .....
SFAN Number: ..... CIS# ..... CIS# .....
Date of Birth: _____ SS# _____ Client ZIP Code: _____

Has the client signed the Consent to Release and Exchange Information? ___
Proof of HIV+ Status> _____
Current HIV Level> _____
HIV Level at Original SDIS Intake> .....
Current TB Status> _____
TB Status at Original SDIS Intake> .....
Year of HIV+ Diagnosis> _____
Country where HIV diagnosis was made> _____
State where HIV diagnosis was made> __ Within Dade County? ___
Case Review Date: ..... Original Intake Date: .....
Registered by> ..... on: ..... at> .....
Reg Edited by> ..... on: ..... at> .....

****

RYAN WHITE - CLIENT INTAKE FORM (SCREEN 2)

Client Name: ..... CIS# .....

Employment Status> _____
Occupation: ..... Family Support> _____
Annual Income: _____ Household Size: ___ # of Dependent Children: ___
Current Source of Income> _____
Income Verification> _____
% Fed. Poverty Level> .....
Last Assessed: .....

Gender> _____ Pregnant during this year? [Y/N] ___ AZT? [Y/N/R] _____
Race> _____ Hispanic? _____ Ethnicity> _____
Primary Language> _____ Country of Birth> _____
Homebound [Y/N] ____ MD Certified Home Meals? ... VA Benefits [Y/N] ___
MD Certified Home Health Care? ...
Primary HIV Exposure Category> _____
Secondary HIV Exposure>> .....
Enter CD4 and/or Viral Load results? ...
Registered by> ..... on: ..... at> .....
Reg Edited by> ..... on: ..... at> .....

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RYAN WHITE TITLE I
SERVICE DELIVERY INFORMATION SYSTEM (SDIS)
CLIENT LEVEL INTAKE INFORMATION

RYAN WHITE - CLIENT INTAKE FORM (SCREEN 3)

L/Name: _____ F/N: _____ M: . CIS ID# .....
SFAN# ..... JMH ID# ..... Exp: ..... CIS# .....

Address 1: ..... 2: .....
Zip Code> ..... City: ..... St> .. OK To Send Mail? ...

Proof of Residency> _____

Living Arrangements>> .....

CADR Housing Arrangements> _____

Day Phone: ..... Evening Phone: .....

Ok to leave message identifying an AIDS agency? [Y/N] Day? ... Eve? ...

Names of People We Can Talk to or Leave a Message With:

.....

Registered by> ..... on: ..... at> .....
Reg Edited by> ..... on: ..... at> .....

****

RYAN WHITE - CLIENT INTAKE FORM (SCREEN 4)

L/Name: _____ F/N: _____ M: . CIS ID# .....
SFAN# ..... JMH ID# ..... Exp: ..... CIS# .....

CM> ..... Case Management Site> .....

Primary Medical Insurance Source> _____
Insurance Status>> _____

Insurance Company> ..... Policy# .....
Drug Limitations: .....
Cap on Drugs $ .....

Screened for Medicaid [Y/N] ___ by> _____ on: _____
Medicaid# ..... Medicaid Control# .....
Update / View Public Benefits Information [Y/N] ...
CADR Enrollment Status>.....

Registered by> ..... on: ..... at> .....
Reg Edited by> ..... on: ..... at> .....

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RYAN WHITE TITLE I
SERVICE DELIVERY INFORMATION SYSTEM (SDIS)
CLIENT LEVEL INTAKE INFORMATION

RYAN WHITE - CLIENT INTAKE FORM (SCREEN 5)

Client Name: ..... CIS# .....

IN EMERGENCY, NOTIFY:
Name: ..... Relationship> .....
Address: .....
Zip Code> ..... City: ..... State> ..
Day Phone # ..... Evening Phone # .....

MEDICAL INFORMATION
Healthcare Provider> .....
Physician Name> ..... Phone: .....
Address Line 1: ..... Line 2: .....
City: ..... State> .. Zip Code> .....
FAX# .....

Chemical Dependency? [Y/N] ... Pre/Newly Released Prisoner? [Y/N] ...
Severe Mental Illness? [Y/N] ...

CADR Enrollment Status>
.....
Last Filed: ..... at Site> .....
Was the CDC Case Report sent to HRS? [Y/N] ___ Date: _____

****

FYI ONLY -
DO NOT COMPLETE AT THIS TIME

RFP No. RW1401
ATTACHMENT 31

OMB No.: 0915-0253
Exp. Date: 04/30/2005

Ryan White CARE Act Data Report
(CARE Act Data Report)
(Cross-Title Data Report)

COVER PAGE

All Ryan White CARE Act grantees should complete this cover page and submit one copy together with all your providers' completed reports. For definition of grantee of record, please refer to the instructions for completing this form.

Name of grantee of record: _____

Grantee of record taxpayer ID #: ☐☐ - ☐☐☐☐☐☐☐

Under which CARE Act titles does your agency contract for or provide services? (Check all that apply.)

☐ Title I ☐ Title II ☐ Title III ☐ Title IV ☐ Title IV Adolescent Initiative

Please identify your CARE Act grant(s) by supplying your grantee identification and/or grant numbers below. Also, enter the number of agencies that received direct funding from you under each title, and the number of CARE Act Data Reports (CADRs) included in your submission containing data from these agencies. Count your own agency in both the # Providers and # CADRs columns if you completed a CADR. Note that the number of CADRs may or may not match the number of providers.

Grant	Grantee ID or Grant Number	# Providers	# CADRs
Title I	9 9 ☐ ☐	_____	_____
Title II	☐ ☐ 0 0	_____	_____
Title III	H76HA - ☐☐☐☐☐	_____	_____
Title IV	H12HA - ☐☐☐☐☐	_____	_____
Title IV Adolescent Initiative	H12HA - ☐☐☐☐☐	_____	_____

What is the total unduplicated number of agencies that received CARE Act funding from you? _____
(This number should match the total number of agencies reported on your Provider Verification Form.)

What is the total number of CADRs (Web and paper) included in your submission package? _____

Name of grantee representative responsible for quality assurance: _____

Signature: _____

Grantee contact email address: _____ @ _____

PUBLIC BURDEN STATEMENT: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB number. The OMB control number for this project is 0915-0253. Public reporting burden for this collection of information is estimated as follows: 65 hours per response for Title I programs; 80 hours per response for Title II programs; 48 hours for Title III programs; 56 hours for Title IV programs; and, 48 hours for programs funded under multiple titles. These estimates include the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information.

Each provider must complete one CADR for all clients served during the reporting period.

SECTION 1. SERVICE PROVIDER INFORMATION

Section 1 (Items 1–23) should be completed by service providers funded through Ryan White CARE Act Titles I, II, III, and IV. For definition of service provider, please refer to the Ryan White CARE Act Data Report instructions.

Part 1.1. Provider and Agency Contact Information

1. Provider name:

_____

2. Provider address:

a. Street: _____

b. City: _____ State: _____

c. ZIP code: _ _ _ _ _ - _ _ _ _

d. Taxpayer ID #: _ _ - _ _ _ _ _ _ _

3. Contact information:

a. Name: _____

b. Title: _____

c. Phone #: (_ _ _) _ _ _ - _ _ _ _

d. Fax #: (_ _ _) _ _ _ - _ _ _ _

e. Email: _____

4. Person completing this form:

a. Name: _____

b. Phone #: (_ _ _) _ _ _ - _ _ _ _

Part 1.2. Reporting and Program Information

5. Calendar year for reporting: (mm/dd/yyyy)

Start date: _ _ / _ _ / _ _ _ _

End date: _ _ / _ _ / _ _ _ _

6. Reporting scope: _ _ *(Select one only.)*

01 = **ALL** Clients receiving a service **ELIGIBLE** for Title I, II, III or IV funding

02 = **ONLY** Clients receiving a Title I, II, III or IV **FUNDED** service

Remember: All grantees and providers must use reporting scope "01" unless they have permission from their HRSA project officer to use "02." All subsequent items regarding "clients" should be answered relative to the reporting scope you select here.

7. Provider type: *(Select one only.)*

- ☐ Hospital or university-based clinic
- ☐ Publicly funded community health center *(go to #8)*
- ☐ Publicly funded community mental health center
- ☐ Other community-based service organization (CBO)
- ☐ Health department
- ☐ Substance abuse treatment center
- ☐ Solo/group private medical practice
- ☐ Agency reporting for multiple fee-for-service providers
- ☐ PLWHA coalition
- ☐ VA facility
- ☐ Other facility

8. *(If "Publicly funded community health center" in #7,)* **Did you receive funding under Section 330 of Public Health Service Act (funds community health centers, migrant health centers, and health care for the homeless) during this reporting period?**

☐ Yes ☐ No ☐ Don't know/unsure

9. Ownership status: *(Select only one.)*

- ☐ Public/local
- ☐ Public/State
- ☐ Public/Federal
- ☐ Private, nonprofit (not faith-based)
- ☐ Private, for-profit
- ☐ Unincorporated
- ☐ Faith-based organization
- ☐ Other

OMB No.: 0915-0253
Exp. Date: 04/30/2005

Each provider must complete one CADR for all clients served during the reporting period.

10. Source of Ryan White CARE Act funding: *(Check all that apply)*

☐ Title I
Name of grantee(s):
1. _____
2. _____
3. _____

☐ Title II
Name of grantee(s):
1. _____
2. _____

☐ Title III
Name of grantee(s):
1. _____
2. _____

☐ Title IV
Name of grantee(s):
1. _____
2. _____

☐ Title IV Adolescent Initiative
Name of grantee(s):
1. _____
2. _____

11. During this reporting period, did you provide the grantee with support in . . . ? *(Check "yes" or "no" for each service.)*

a. Planning or evaluation	☐ Yes	☐ No
b. Administrative or technical support	☐ Yes	☐ No
c. Fiscal intermediary services	☐ Yes	☐ No
d. Technical assistance	☐ Yes	☐ No
e. Capacity development	☐ Yes	☐ No
f. Quality management	☐ Yes	☐ No

☐ Check if any of these services were the **only** services you provided under CARE Act funding. If so, **STOP HERE** and do not complete the remainder of this form.

(Third party administrators who process fee-for-service reimbursements to providers of eligible services should continue.)

NOTE: Those who provided a direct service other than those listed in #11, continue with #12 and answer items only as they relate to the client services you provided. **ALL OTHERS STOP HERE.**

12. Did you administer an AIDS Drug Assistance Program (ADAP) or local pharmaceutical assistance program that provides HIV/AIDS medication to clients during this reporting period?

☐ Yes *(Continue.)*
☐ No *(Skip to #14.)*

13. *(If "yes" to #12,)* **Type of program administered:**

☐ State ADAP *(If this was the **only** service you provided under CARE Act funding, skip to Section 7.)*
☐ Local pharmaceutical assistance program that provides HIV/AIDS medication to clients *(If this was the **only** service you provided under CARE Act funding, skip to Section 7.)*

14. Did you provide a Health Insurance Program (HIP) during this reporting period?

☐ Yes *(If this was the **only** service you provided under CARE Act funding, skip to Section 8.)*
☐ No

☐ Check if the only services your agency provide are ADAP and HIP. *(Skip to Sections 7 & 8.)*

15. Indicate which of the following populations were especially targeted for outreach or services during this reporting period. *(Check box for each group targeted.)*

☐ Migrant or seasonal farm workers
☐ Rural populations other than migrant or seasonal farm workers
☐ Women
☐ Children
☐ Racial/ethnic minorities/communities of color
☐ Homeless
☐ Gay, lesbian, and bisexual youth
☐ Gay, lesbian, and bisexual adults
☐ Incarcerated persons
☐ All adolescents
☐ Runaway or street youth
☐ Injection drug users
☐ Non-injection drug users
☐ Parolees
☐ Other (specify:_____)

Each provider must complete one CADR for all clients served during the reporting period.

16. Which of the following categories describes your agency? *(Check all that apply.)*

- ☐ An agency in which racial/ethnic minority group members make up greater than 50% of the agency's board members
- ☐ Racial/ethnic minority group members make up greater than 50% of the agency's professional staff members in HIV direct services
- ☐ Solo or group private health care practice in which greater than 50% of the clinicians are racial/ethnic minority group members
- ☐ Other "traditional" provider that has historically served racial/ethnic minority patients/clients but does not meet the criteria above
- ☐ Other type of agency or facility

17. Total paid staff, in FTEs, funded by any Title of the CARE Act:

_____ Paid staff FTEs

18. Total volunteer staff, in FTEs, dedicated to HIV care:

_____ Volunteer staff FTEs

19. Amount of Title I funding received during this reporting period *(rounded to the nearest dollar)*:

$_____

20. Amount of Title II funding received during this reporting period *(rounded to the nearest dollar)*:

$_____

21. Amount of Title III funding received during this reporting period *(rounded to the nearest dollar)*:

$_____

22. Amount of Title IV funding received during this reporting period *(rounded to the nearest dollar)*:

$_____

23. Amount of Title I, II, III, or IV Ryan White CARE Act funds EXPENDED on oral health care during this reporting period *(rounded to the nearest dollar)*:

$_____

Each provider must complete one CADR for all clients served during the reporting period.

SECTION 2. CLIENT INFORMATION

*Service providers from **all Titles** should complete this section. Clients reported in this section should include your HIV-infected and affected population, whether receiving medical care or social support services. Affected clients include those who are HIV negative as well as those with unknown HIV status. An affected client must be linked to a client infected with HIV/AIDS.*

Remember your reporting scope! If you chose Reporting Scope 01 in Item 6, provide information on all clients who received a service eligible for CARE Act funding. If you chose Reporting Scope 02 in Item 6, include only clients who received services funded by Titles I, II, III, and/or IV.

24. Total number of unduplicated clients:

_____ HIV positive
_____ HIV negative (affected)
_____ Unknown/unreported (affected)
_____ Total

25. Total number of new clients:

_____ HIV positive
_____ HIV negative (affected)
_____ Unknown/unreported (affected)
_____ Total

26. Gender:

Number of clients:	*HIV positive*	*HIV affected*
Male		
Female		
Transgender		
Unknown/unreported		
Total		

27. Age (at the end of reporting period):

Number of clients:	*HIV positive*	*HIV affected*
Less than 2 years		
2–12 years		
13–24 years		
25–44 years		
45–64 years		
65 years or older		
Unknown/unreported		
Total		

28. Hispanic or Latino/a ethnicity:

Number of clients:	*HIV positive*	*HIV affected*
Hispanic or Latino/a		
Non-Hispanic or Non-Latino/a		
Unknown/unreported		
Total		

29. Race (all clients reported in Item 28 must be included in this Item):

Number of clients:	*HIV positive*	*HIV affected*
White		
Black or African American		
Asian		
Native Hawaiian or Other Pacific Islander		
American Indian or Alaskan Native		
More than one race		
Unknown/unreported		
Total		

30. Household income (at the end of reporting period):

Number of clients:	*HIV positive*	*HIV affected*
Equal to or below the Federal poverty line		
101–200% of Federal poverty line		
201–300% of Federal poverty line		
> 300% of Federal poverty line		
Unknown/unreported		
Total		

Each provider must complete one CADR for all clients served during the reporting period.

31. Housing/living arrangements (at the end of reporting period):

Number of clients:	*HIV positive*	*HIV affected*
Permanently housed	_____	_____
Non-permanently housed	_____	_____
Institution	_____	_____
Other	_____	_____
Unknown/unreported	_____	_____
Total	_____	_____

32. Medical insurance (at the end of reporting period):

Number of clients:	*HIV positive*	*HIV affected*
Private	_____	_____
Medicare	_____	_____
Medicaid	_____	_____
Other public	_____	_____
No insurance	_____	_____
Other	_____	_____
Unknown/unreported	_____	_____
Total	_____	_____

33. HIV/AIDS status (at the end of reporting period):

Number of clients:	*HIV positive*	*HIV affected*
HIV positive, not AIDS	_____	
HIV positive, AIDS status unknown	_____	
CDC-defined AIDS	_____	
HIV negative (affected clients only)		_____
Unknown/unreported (affected clients only)		_____
Total	_____	_____

34. Clients' vital/enrollment status (at the end of reporting period):

Number of clients:	*HIV positive*	*HIV affected*
Active, client new to program	_____	_____
Active, client continuing in program	_____	_____
Deceased	_____	_____
Inactive	_____	_____
Unknown/unreported	_____	_____
Total	_____	_____

Each provider must complete one CADR for all clients served during the reporting period.

SECTION 3. SERVICE INFORMATION

*Service providers from **all Titles** should complete this section. If you provided a particular service, check the box in column 2 and list the number of clients and the total number of visits for the appropriate service categories. If you provided a particular service but do not know the number of clients or visits during the reporting period, check the unknown box.*

35. Services provided, number of clients served, and total number of visits during this reporting period:

	1 Service Categories	2 Check if service was provided	3a Total # of unduplicated clients		3b Check if # of clients unknown	4a Total # of visits during reporting period		4b Check if # of visits unknown
			HIV+	Affected		HIV+	Affected	
a.	Ambulatory/outpatient medical care			[redacted]			[redacted]	
b.	Mental health services							
c.	Oral health care							
d.	Substance abuse services–outpatient							
e.	Substance abuse services–residential							
f.	Rehabilitation services							
g.	Home health: para-professional care							
h.	Home health: professional care							
i.	Home health: specialized care							
j.	Case management services							
k.	Buddy/companion service					[redacted]		
l.	Child care services							
m.	Child welfare services							
n.	Client advocacy							
o.	Day or respite care for adults							
p.	Developmental assessment/early intervention services							
q.	Early intervention services for Titles I and II							
r.	Emergency financial assistance							
s.	Food bank/home-delivered meals							
t.	Health education/risk reduction							
u.	Housing services							
v.	Legal services							
w.	Nutritional counseling							
x.	Outreach services							
y.	Permanency planning							
z.	Psychosocial support services							
aa.	Referral for health care/supportive services							
ab.	Referrals to clinical research							
ac.	Residential or in-home hospice care							
ad.	Transportation services							
ae.	Treatment adherence counseling							
af.	Other services							

Each provider must complete one CADR for all clients served during the reporting period.

SECTION 4. HIV COUNSELING AND TESTING

Title I, II, III, and IV grantees/service providers who selected the eligible reporting scope (01), and provide HIV-antibody counseling and testing, must report on all items in Section 4. Those who selected the funded reporting scope (02), and provide HIV-antibody counseling and testing, but do not use CARE Act funds, should respond to #36 and #37, then skip to Section 5.

NOTE: Based on Ryan White CARE Act reauthorization, HIV counseling and testing are funded as components of Early Intervention Services for Titles I and II.

*Report only on the number of individuals who received HIV counseling and testing during the reporting period. Until these individuals receive at least one of the services listed in Section 3, they are **NOT** considered clients.*

36. a. Was HIV counseling and testing provided as part of your program during this reporting period?

☐ Yes *(Continue.)*
☐ No *(Skip to Section 5.)*

36. b. Indicate the total number of infants tested during this reporting period.

_____ Number of infants tested

37. Were Ryan White CARE Act funds used to support HIV counseling and testing services during this reporting period?

☐ Yes *(Continue.)*

☐ No *(Skip to Section 5, if you selected scope 02 and do not wish to continue with this section.)*

38. How many individuals received HIV pretest counseling during this reporting period?

Number of:

_____ Confidential

_____ Anonymous

(If answer to both categories is "0," skip to #43.)

39. Of the individuals who received HIV pretest counseling *(#38 above)*, **how many were tested for HIV antibodies during this reporting period?**

Number of:

_____ Confidential

_____ Anonymous

40. Of the individuals who received pretest counseling and were tested for HIV antibodies *(#39 above)*, **how many had a positive test result during this reporting period?**

_____

41. Of the individuals who received HIV pretest counseling and were tested for HIV antibodies *(#39 above)*, **how many received HIV posttest counseling during this reporting period, regardless of test results?**

Number of:

_____ Confidential

_____ Anonymous

42. Of the individuals who tested POSITIVE *(#40 above)*, **how many did NOT return for HIV posttest counseling during this reporting period?**

_____

43. Did your program offer partner notification services during this reporting period?

☐ Yes *(Continue.)*

☐ No *(Skip to Section 5.)*

44. *(If "yes" in #43,)* **How many at-risk partners were notified during this reporting period?**

_____

Each provider must complete one CADR for all clients served during the reporting period.

SECTION 5. MEDICAL INFORMATION

*This section should be completed by **all medical service providers** funded through Ryan White CARE Act Titles I, II, III, or IV and should include only clients who are HIV positive who had at least one ambulatory/outpatient medical care visit during the reporting period.*

45. Total number of unduplicated clients reporting on in this section by gender:

_____ Male
_____ Female
_____ Transgender
_____ Unknown/unreported
_____ Total

46. Total number of clients who are HIV positive with each of the listed risk factors for HIV infection:

Persons with more than one reported mode of exposure to HIV are counted in the exposure category listed first in the hierarchy, except for persons with a history of both homosexual/bisexual contact and injection drug use. They are counted in a separate category, i.e., MSM and IDU.

_____ Men who have sex with men (MSM)
_____ Injection drug user (IDU)
_____ Men who have sex with men and injection drug user (MSM and IDU)
_____ Hemophilia/coagulation disorder
_____ Heterosexual contact
_____ Receipt of transfusion of blood, blood components, or tissue
_____ Mother with/at risk for HIV infection (perinatal transmission)
_____ Other
_____ Undetermined/unknown/risk not reported or identified
_____ Total

47. Number of clients who received each of the following at any time during this reporting period:

_____ TB skin test (PPD Mantoux)
_____ Treatment due to a positive TB skin test
_____ Screening/testing for syphilis
_____ Treatment for syphilis
_____ Screening/testing for any treatable sexually transmitted infection (STI) other than syphilis and HIV
_____ Treatment for an STI (other than syphilis and HIV)
_____ Screening/testing for hepatitis C
_____ Treatment for hepatitis C

48. Number of clients diagnosed with each AIDS-defining condition during this reporting period:

_____ Pneumocystis carinii pneumonia (PCP)
_____ Mycobacterium avium complex (MAC)
_____ Mycobacterium tuberculosis
_____ Cytomegalovirus disease
_____ Toxoplasmosis
_____ Cervical cancer
_____ Other AIDS-defining condition

49. Number of clients on the following antiretroviral therapies at the end of the reporting period:

_____ None
_____ HAART
_____ Salvage
_____ Other (mono or dual therapy)
_____ Unknown/unreported
_____ Total

50. Number of clients who received a pelvic exam and Pap smear during this reporting period:

_____

51. Number of clients who are HIV positive who were pregnant during this reporting period:

_____

52. Of the number of pregnant clients who are HIV positive *(#51 above)*, number entering care in the:

_____ First trimester
_____ Second trimester
_____ Third trimester
_____ At time of delivery
_____ Total

53. Number of pregnant clients *(#51 above)* who received antiretroviral medications to prevent the transmission of HIV to their children:

_____

54. Number of children delivered to clients who are HIV positive *(#51 above)*:

_____

55. Of the number of children delivered *(#54 above)*, number HIV positive:

_____

Each provider must complete one CADR for all clients served during the reporting period.

SECTION 6. DEMOGRAPHIC TABLES/TITLE-SPECIFIC DATA FOR TITLES III AND IV

Part 6.1 should be completed by Title III grantees/service providers. Part 6.2 should be completed by Title IV grantees/service providers. Title I and II grantees should skip to Section 7.

Part 6.1. Title III Information

Part 6.1 should be completed by Title III grantees/service providers only. When reporting on patients in this section, only report on clients who are HIV positive who had at least one ambulatory/outpatient medical care visit during the reporting period.

56. Number of patients who are HIV positive during this reporting period by Hispanic or Latino/a ethnicity, gender, and age.

Ethnicity/Origin	Gender	Under 2 years	2–12 years	13–24 years	25–44 years	45–64 years	65 years and older	Age unknown	Total
Hispanic or Latino/a	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Non-Hispanic or Non-Latino/a	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Unknown/ unreported	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Total	Male								
	Female								
	Transgender								
	Unknown/ unreported								

Each provider must complete one CADR for all clients served during the reporting period.

57. Number of patients who are HIV positive during this reporting period by race, gender, and age. *(All Hispanic or Latino/a patients reported in Table 56 should also be included in this table.)*

Race	Gender	Under 2 years	2–12 years	13–24 years	25–44 years	45–64 years	65 years and older	Age unknown	Total
White	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Black or African American	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Asian	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Native Hawaiian or Other Pacific Islander	Male								
	Female								
	Transgender								
	Unknown/ unreported								
American Indian or Alaskan Native	Male								
	Female								
	Transgender								
	Unknown/ unreported								
More than one race	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Unknown/ unreported	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Total	Male								
	Female								
	Transgender								
	Unknown/ unreported								

Each provider must complete one CADR for all clients served during the reporting period.

58. Number of patients who are HIV positive during this reporting period by HIV exposure category, gender, and race.

HIV Exposure Category	Gender	White	Black or African American	Asian	Native Hawaiian or other Pacific Islander	American Indian/ Alaskan Native	More than one race	Race unknown	Total
Men who have sex with men (MSM)	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Injection drug user (IDU)	Male								
	Female								
	Transgender								
	Unknown/ unreported								
MSM and IDU	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Hemophilia/ coagulation disorder	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Heterosexual contact	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Receipt of transfusion of blood, blood components, or tissue	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Mother with/at risk for HIV infection (perinatal transmission)	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Other	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Unknown/ unreported	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Total	Male								
	Female								
	Transgender								
	Unknown/ unreported								

Each provider must complete one CADR for all clients served during the reporting period.

59. Number of patients who are HIV positive during this reporting period by HIV exposure category, gender, and age.

HIV Exposure Category	Gender	Under 2 years	2–12 years	13–24 years	25–44 years	45–64 years	65 years and older	Age unknown	Total
Men who have sex with men (MSM)	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Injection drug user (IDU)	Male								
	Female								
	Transgender								
	Unknown/ unreported								
MSM and IDU	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Hemophilia/ coagulation disorder	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Heterosexual contact	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Receipt of transfusion of blood, blood components, or tissue	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Mother with/at risk for HIV infection (perinatal transmission)	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Other	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Unknown/ unreported	Male								
	Female								
	Transgender								
	Unknown/ unreported								
Total	Male								
	Female								
	Transgender								
	Unknown/ unreported								

Each provider must complete one CADR for all clients served during the reporting period.

60. Cost and revenue of primary care* and other programs† during this reporting period:

a. Total cost of providing service:

$_____ Primary care

$_____ Other program

b. Title III grant funds **expended:**

$_____ Primary care (excluding pharmaceuticals)

$_____ Other program

$_____ Pharmaceuticals

c. Direct collections from patients:

$_____ Primary care

$_____ Other program

d. Reimbursements received from third party payer:

$_____ Primary care

$_____ Other program

e. All other sources of income:

$_____ Primary care

$_____ Other program

*Includes medical, subspecialty care, dental, nutrition, mental health and substance abuse treatment, and pharmacy services; radiology, laboratory and other tests for diagnosis and treatment planning; HIV counseling and testing; and the cost of making and tracking referrals for medical care.

†Includes case management and eligibility assistance, outreach, social work, prevention education and harm reduction. If you are providing a Title III-eligible service, include it, even if it is not being funded under your grant.

61. Were services available through your Early Intervention Services (EIS) program provided at more than one site during this reporting period?

☐ Yes *(Continue.)*

☐ No *(Skip to #63.)*

62. *(If "yes" to #61,)* **Number of sites at which EIS services were provided during this reporting period:**

_____

63. Please indicate which of the following primary health care services were made available to your clients who are HIV positive during this reporting period. *(Choose "within the EIS program" if you provided the service directly and/or through a contractual relationship with another service provider. Choose "through referral" if it was offered by another agency with which you had no remunerative relationship but to whom you referred. Choose "No" if the service was not available.)*

	Yes, within the EIS program ▼	Yes, through referral ▼	No ▼
a. Ambulatory/outpatient medical care	☐		
b. Dermatology	☐	☐	☐
c. Dispensing of pharmaceuticals	☐	☐	☐
d. Gastroenterology	☐	☐	☐
e. Mental health services	☐	☐	☐
f. Neurology	☐	☐	☐
g. Nutritional counseling	☐	☐	☐
h. Obstetrics/gynecology	☐	☐	☐
i. Optometry/ophthalmology	☐	☐	☐
j. Oral health care	☐	☐	☐
k. Rehabilitation services	☐	☐	☐
l. Substance abuse services	☐	☐	☐
m. Other services	☐	☐	☐
n. Not applicable	☐		

64. How many unduplicated patients who are HIV positive were referred outside the EIS program for any health service that was not available within the EIS program during this reporting period?

_____

Each provider must complete one CADR for all clients served during the reporting period.

Part 6.2. Title IV Information

Part 6.2 should be completed by Title IV grantees/service providers only. Clients who are HIV negative/unknown (affected) who are reported in this section must be a family member or partner of a client who is HIV positive. Include only those clients who received Title IV services.

65. **Number of clients during this reporting period by gender, HIV status, and age.**

Gender	HIV Status	Under 2 years	2–12 years	13–24 years	25–44 years	45–64 years	65 years and older	Age unknown	Total
Male	HIV positive								
	HIV-/unknown								
Female	HIV positive								
	HIV-/unknown								
Transgender	HIV positive								
	HIV-/unknown								
Unknown/ unreported	HIV positive								
	HIV-/unknown								
Total	HIV positive								
	HIV-/unknown								

66. **Number of clients during this reporting period by Hispanic or Latino/a ethnicity, HIV status, and age.**

Ethnicity/Origin	HIV Status	Under 2 years	2–12 years	13–24 years	25–44 years	45–64 years	65 years and older	Age unknown	Total
Hispanic or Latino/a	HIV positive								
	HIV-/unknown								
Non-Hispanic or Non-Latino/a	HIV positive								
	HIV-/unknown								
Unknown/ unreported	HIV positive								
	HIV-/unknown								
Total	HIV positive								
	HIV-/unknown								

Each provider must complete one CADR for all clients served during the reporting period.

67. Number of clients during this reporting period by race, HIV status, and age. *(All Hispanic and Latino/a clients reported in Table 66 should also be included in this table.)*

Race	HIV Status	Under 2 years	2–12 years	13–24 years	25–44 years	45–64 years	65 years and older	Age unknown	Total
White	HIV positive								
	HIV-/unknown								
Black or African American	HIV positive								
	HIV-/unknown								
Asian	HIV positive								
	HIV-/unknown								
Native Hawaiian or Other Pacific Islander	HIV positive								
	HIV-/unknown								
American Indian or Alaskan Native	HIV positive								
	HIV-/unknown								
More than one race	HIV positive								
	HIV-/unknown								
Unknown/ unreported	HIV positive								
	HIV-/unknown								
Total	HIV positive								
	HIV-/unknown								

68. Number of clients who are <u>HIV POSITIVE</u> during this reporting period by HIV exposure category and age.

HIV Exposure Category	Under 2 years	2–12 years	13–24 years	25–44 years	45–64 years	65 years and older	Age unknown	Total
Men who have sex with men (MSM)								
Injection drug user (IDU)								
MSM and IDU								
Hemophilia/coagulation disorder								
Heterosexual contact								
Receipt of transfusion of blood, blood components, or tissue								
Mother with/at risk for HIV infection (perinatal transmission)								
Other								
Undetermined/unknown								
Total								

STOP HERE IF YOU DO NOT PROVIDE ADAP OR HIP TO YOUR CLIENTS!

Each provider must complete one CADR for all clients served during the reporting period.

SECTION 7. APA INFORMATION

This section should be completed by all Ryan White CARE Act Title II grantees who administer their State AIDS Drug Assistance Program or Title I/II-funded grantees who administer a local AIDS pharmaceutical assistance (APA) program. This section should **not** *be completed by CARE Act programs that provide* ***funding*** *to pharmaceutical programs but do not provide pharmacy services or administer pharmacy programs.*

A State ADAP program is an AIDS Drug Assistance Program administered by a State or Territory.

1. Medical eligibility: *(Check all that apply.)*

- ☐ CD4 lymphocyte count
- ☐ HIV positive
- ☐ Other

2. Average application processing period:

- ☐ Less than 5 days
- ☐ 5–10 days
- ☐ 11–30 days
- ☐ 31–60 days
- ☐ More than 60 days

3. Frequency of recertification:

- ☐ Quarterly
- ☐ Semi-annually
- ☐ Annually
- ☐ Other
- ☐ Not applicable

4. Total number of *UNDUPLICATED* clients in this reporting period:

_____

5. Total number of *NEW* clients served in this reporting period:

_____

6. Gender:

Number of clients:

_____ Male
_____ Female
_____ Transgender
_____ Unknown/unreported
_____ Total

7. Age (at the end of reporting period):

Number of clients:

_____ Less than 2 years
_____ 2–12 years
_____ 13–24 years
_____ 25–44 years
_____ 45–64 years
_____ 65 years or older
_____ Unknown/unreported
_____ Total

8. Hispanic or Latino/a ethnicity:

Number of clients:

_____ Hispanic or Latino/a ethnicity
_____ Non-Hispanic or non-Latino/a ethnicity
_____ Unknown/unreported
_____ Total

9. Race:

Number of clients:

_____ White
_____ Black or African American
_____ Asian
_____ Native Hawaiian or Other Pacific Islander
_____ American Indian or Alaskan Native
_____ More than one race
_____ Unknown/unreported
_____ Total

Each provider must complete one CADR for all clients served during the reporting period.

Agency Fiscal Information

10. Annual funding for APA/ADAP by CARE Act sources:

Funding source	Funding received
Total Title I funds	$ _ _, _ _ _, _ _ _
EMA #1 _ _ _ _	$ _ _, _ _ _, _ _ _
EMA #2 _ _ _ _	$ _ _, _ _ _, _ _ _
EMA #3 _ _ _ _	$ _ _, _ _ _, _ _ _
EMA #4 _ _ _ _	$ _ _, _ _ _, _ _ _
EMA #5 _ _ _ _	$ _ _, _ _ _, _ _ _
EMA #6 _ _ _ _	$ _ _, _ _ _, _ _ _
EMA #7 _ _ _ _	$ _ _, _ _ _, _ _ _
EMA #8 _ _ _ _	$ _ _, _ _ _, _ _ _
EMA #9 _ _ _ _	$ _ _, _ _ _, _ _ _
EMA #10 _ _ _ _	$ _ _, _ _ _, _ _ _
Total Title II funds	$ _ _, _ _ _, _ _ _
Other CARE Act funding	$ _ _, _ _ _, _ _ _

11. Annual funding for APA/ADAP by other sources:

Funding source	Funding received
Federal Section 330	$ _ _, _ _ _, _ _ _
Other Federal funding	$ _ _, _ _ _, _ _ _
State/local	$ _ _, _ _ _, _ _ _
Client payments	$ _ _, _ _ _, _ _ _
Manufacturer rebates	$ _ _, _ _ _, _ _ _
All other sources not included above	$ _ _, _ _ _, _ _ _

12. Annual expenditures for health insurance services within APA or ADAP:

Source	Total cost	Unduplicated clients	Total client-months
a. High-risk insurance pool			
Premiums	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
Deductibles	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
Co-payments	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
b. Medicare supplement			
Premiums	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
Deductibles	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
Co-payments	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
c. Other health insurance			
Premiums	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
Deductibles	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
Co-payments	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
TOTAL HEALTH INSURANCE EXPENDITURES			
Premiums	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
Deductibles	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
Co-payments	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _

13. Annual expenditures for services under the Flexibility Policy:

_____ Adherence
_____ Access
_____ Monitoring
_____ Total flexibility expenditures

14. Total expenditures: *(Include health insurance, flexibility, PLUS dispensing and other administrative costs.)*

$ _ _ _, _ _ _, _ _ _

Each provider must complete one CADR for all clients served during the reporting period.

15. For each medication prescribed, enter the HRSA drug code, unduplicated number of clients who received that drug, and the total cost.

	Unduplicated # of clients receiving drug	
d_____	___,___	$___,___,___
d_____	___,___	$___,___,___
d_____	___,___	$___,___,___
d_____	___,___	$___,___,___
d_____	___,___	$___,___,___
d_____	___,___	$___,___,___
d_____	___,___	$___,___,___
d_____	___,___	$___,___,___
d_____	___,___	$___,___,___
d_____	___,___	$___,___,___
d_____	___,___	$___,___,___
d_____	___,___	$___,___,___
d_____	___,___	$___,___,___
d_____	___,___	$___,___,___
d_____	___,___	$___,___,___
d_____	___,___	$___,___,___
d_____	___,___	$___,___,___
d_____	___,___	$___,___,___
d_____	___,___	$___,___,___
d_____	___,___	$___,___,___
d_____	___,___	$___,___,___
d_____	___,___	$___,___,___
d_____	___,___	$___,___,___
d_____	___,___	$___,___,___
d_____	___,___	$___,___,___
d_____	___,___	$___,___,___
d_____	___,___	$___,___,___
d_____	___,___	$___,___,___
d_____	___,___	$___,___,___
d_____	___,___	$___,___,___
d_____	___,___	$___,___,___

STOP HERE UNLESS YOU ARE A SERVICE PROVIDER ADMINISTERING HIP.

Each provider must complete one CADR for all clients served during the reporting period.

SECTION 8. HEALTH INSURANCE PROGRAM (HIP) INFORMATION

This section should be completed by the state agency and other entities that used CARE Act funds to pay for or supplement a client's health insurance. This section should **not** *be completed by CARE Act grantees providing funding to another HIP program, or by service providers who ONLY PROVIDE VOUCHERS FOR HEALTH INSURANCE.*

A Health Insurance Program is a program authorized and primarily funded under Title I or Title II of the CARE Act that makes premium payments, co-payments, deductibles, or risk pool payments on behalf of a client to maintain his/her health insurance coverage.

1. Total number of *UNDUPLICATED* clients in this reporting period:

_____

2. Total number of *NEW* clients served in this reporting period:

_____

3. Gender:

Number of clients:

_____ Males
_____ Females
_____ Transgender
_____ Unknown/unreported
_____ Total

4. Age (at the end of reporting period):

Number of clients:

_____ Less than 2 years
_____ 2–12 years
_____ 13–24 years
_____ 25–44 years
_____ 45–64 years
_____ 65 years or older
_____ Unknown/unreported
_____ Total

5. Hispanic or Latino/a ethnicity:

Number of clients:

_____ Hispanic or Latino/a ethnicity
_____ Non-Hispanic or non-Latino/a ethnicity
_____ Unknown/unreported
_____ Total

6. Race:

Number of clients:

_____ White
_____ Black or African American
_____ Asian
_____ Native Hawaiian or Other Pacific Islander
_____ American Indian or Alaskan Native
_____ More than one race
_____ Unknown/unreported
_____ Total

7. Annual expenditures for HIP:

Source	Total cost	Unduplicated clients	Total client-months
a. High-risk insurance pool			
Premiums	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
Deductibles	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
Co-payments	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
b. Medicare supplement			
Premiums	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
Deductibles	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
Co-payments	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
c. Other health insurance			
Premiums	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
Deductibles	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
Co-payments	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
TOTAL HEALTH INSURANCE EXPENDITURES			
Premiums	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
Deductibles	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _
Co-payments	$ _, _ _ _, _ _ _	_ _ _ _	_ _ _, _ _ _

Each provider must complete one CADR for all clients served during the reporting period.

8. Total expenditures: *(Include "Total Health Insurance Expenditures" above plus any other administrative costs.)*

$__ __ , __ __ __, __ __ __

9. Annual funding for HIP by CARE Act funds:

Funding source	Funding received
Total Title I funds	$ _ _, _ _ _, _ _ _
EMA #1 __ __ __ __	$ _ _, _ _ _, _ _ _
EMA #2 __ __ __ __	$ _ _, _ _ _, _ _ _
EMA #3 __ __ __ __	$ _ _, _ _ _, _ _ _
EMA #4 __ __ __ __	$ _ _, _ _ _, _ _ _
EMA #5 __ __ __ __	$ _ _, _ _ _, _ _ _
EMA #6 __ __ __ __	$ _ _, _ _ _, _ _ _
EMA #7 __ __ __ __	$ _ _, _ _ _, _ _ _
EMA #8 __ __ __ __	$ _ _, _ _ _, _ _ _
EMA #9 __ __ __ __	$ _ _, _ _ _, _ _ _
EMA #10 __ __ __ __	$ _ _, _ _ _, _ _ _
Total Title II funds	$ _ _, _ _ _, _ _ _
ADAP funds	$ _ _, _ _ _, _ _ _
Other CARE Act funding	$ _ _, _ _ _, _ _ _

10. Annual funding for HIP by other sources:

Funding source	Funding received
Federal Section 330	$ _ _, _ _ _, _ _ _
Other Federal funding	$ _ _, _ _ _, _ _ _
State/Local	$ _ _, _ _ _, _ _ _
Client payments	$ _ _, _ _ _, _ _ _
All other sources not included above	$ _ _, _ _ _, _ _ _

END OF REPORT

RFP No. RW1401
ATTACHMENT 32

RYAN WHITE - TITLE I
WORKPLAN FOR IMPLEMENTATION OF FUNDED PROGRAM

SERVICE PROVIDER	SERVICE CATEGORY	SERVICE PERIOD

SERVICE OBJECTIVE

Activity/Task (A)	Assigned Staff

Contract Period — Target Date

2004										2005	
Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb

Activity/Task (B)	Assigned Staff

Contract Period — Target Date

2004										2005	
Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb

SERVICE OBJECTIVE

Activity/Task (A)	Assigned Staff

Contract Period — Target Date

2004										2005	
Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb

Activity/Task (B)	Assigned Staff

Contract Period — Target Date

2004										2005	
Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb

Reproduce Copies of this Form as Necessary

Instructions for Completing
Workplan for Implementation of Funded Program Form

Note: A separate workplan is required for each funded service program. Any deviation from an approved workplan will require prior written notification to the County and subsequent written approval.

1. In the **first box**, please type the full legal name of the organization.

2. In the **second box**, please type the service category for which this workplan is being submitted.

3. In the **third box**, please type the period during which the identified service will be offered.

4. Under the box titled **"Service Objective ___"**, please indicate the objective's number, listed in priority order, and define the organization's objective for the proposed service program. Objectives **must** be specific and quantifiable (Example: To begin serving clients by September 2004). Your organization's workplan **must** include, at a minimum, the objectives listed below. Reproduce and attach additional copies as necessary.

5. Under the boxes titled **"Activity/Task"**, please identify the major activities or tasks associated with each objective. The description of the activity/task **must** indicate the target date of when: a) the activity/task will start, b) compliance with standard will be met, or c) the activity/task will be completed.

Note: All organizations must, at a minimum, include the following objectives/activities as part of their workplan:

- **Target date for staff hiring and training, as needed**
- **Target date for all staff on-board, trained, and ready to work**
- **Target service delivery start date (when service will be available to the proposed client population)**
- **Meet or work toward achieving Title I System-wide Standards of Care for client accessibility, quality assurance, administration, etc.**

In addition, providers of case management/PESN services must also include the following objectives/activities as part of their workplan:

- **Meet or work toward achieving case management standards of service [applicable to providers of case management and Peer Education Support Network (PESN) services only]**
- **Meet or work toward achieving compliance with the Title I Coordinated Case Management Standards of Service (applicable to providers of case management and PESN services only)**
- **Staff/training**
- **Information and accessibility**
- **Services and scheduling**
- **Client rights and responsibilities**
- **Coordination and linkage**
- **Quality Assurance (as it pertains to case management services)**
- **Voucher services**

In addition, providers of outpatient medical care (primary care) services must also include the following objectives/activities as part of their workplan:

- **Meet or work toward achieving compliance with Title I Minimum Primary Medical Care Standards for Chart Review**

6. Under the boxes titled **"Assigned Staff"**, please identify the name(s)/title(s) of the individual(s) that will be responsible for meeting your organization's service objectives.

7. Under the box titled **"Target Date"**, please indicate the month/year in which the proposed activity will: a) start, b) compliance with standard will be met, or c) activity will be completed, as indicated under the corresponding "Activity/Task".

RFP No. RW1401
ATTACHMENT 33

RYAN WHITE - TITLE I
SERVICE PROVIDER FUNDING SOURCE SUMMARY

Service Provider	*Provider's Fiscal Year*

Funding Source	Program Description/ Services to be provided	Dollar Amount	Contract Period

Reproduce Copies of this Form as Necessary

Instructions for Completing
Service Provider Funding Source Summary Form

1. Under the title "Service Provider," please type the full legal name of the proposing organization.

2. Under the title "Provider's Fiscal Year," please type the fiscal year of the proposing organization.

3. In the column titled "Funding Source," please identify all non-Title I sources from which the proposing organization will draw funds to cover the costs associated with the provision of the services indicated under the column titled "Program Description / Services to be provided" (i.e., Title II, Title III, State care and treatment, other federal, state, local and private foundation grants, and approximate amounts billed to Medicaid, Medicaid Waiver, Medically Needy, Medicare, etc.).

4. In the column titled "Program Descriptions/Services to be Provided, please submit a brief description of the service(s) that will be covered under the funding source indicated in the previous column.

5. In the column titled "Dollar Amount," please enter the total dollars awarded to the proposing organization by the previously identified funding source.

6. In the last column, please indicate the effective period for each source of funding (i.e., contract period).

7. Reproduce and attach additional copies as necessary.

RYAN WHITE TITLE I
CERTIFIED REFERRAL / RE-CERTIFICATION INFORMATION

THE FOLLOWING IS AN EXCERPT OF SCREENS FROM THE SERVICE DELIVERY INFORMATION SYSTEM (SDIS) INDICATING FIELDS WHICH ARE REQUIRED FOR THE PURPOSE OF ISSUING A TITLE I CERTIFIED REFERRAL:

I. REFERRAL/RECERTIFICATION - CLIENT INFORMATION

Client Name: _____ SS# .....
Referral ID# _____ Refer to Agency> .....
Initial Referral: ..... Recertification: .....

Address: ..... Apt# ..... DOB: .....
City: ..... State> .. Zip: ..... Tel# .....
Proof of Residency> _____

CIS ID# ..... JMH ID# ..... Medicaid# .....
SFAN ID# ..... CIS# ..... Medicare# .....
Insurance Status>> .....
Insurance Company> ..... Policy# .....
Drug Limitations: .....
Cap on Drugs $ .....
Additional/Special Instructions:
.....
.....
.....
.....
Referral Last Worked: .....
Referral Made by> ..... at> .....

****

II. REFERRAL/RECERTIFICATION - TYPE OF ASSISTANCE REQUESTED
(check all that apply)

Name: ..... CIS# .....

Client Referred to> _____

Case Management ...	Dental Care - Basic ...
Legal Assistance ...	Dental Care - Specialty* ...
OP Medical Care - Specialty* ...	OP Medical Care - Primary ...
Prescription Drugs* ...	Home Health Services* ...
Psychosocial Counseling ...	Day Care Services ...
	Substance Abuse Counseling:
	Residential? ... Outpatient? ...

Insurance:
- AIDS Insurance Continuation Program ...
- Insurance Deductible ...
- Prescription Drug Co-Payments* ...

****

Grocery Assistance $ ..... Food Bank? ...
Personal Hygiene Vouchers? ...
Home Delivered Meals? ...
Transportation Assistance $ ..... Metro Pass? ... Tokens? ...
Utility Assistance* $ ..... Water? ... Electric? ...
Gas? ... Telephone? ...

Since this client has received services in total of:

Transportation Assistance $ .....
Utility Assistance $ .....

*Write the Referral ID# and Agency Name on the prescription/bill, ensure that the client name is legible, and fax it to the receiving agency.

****

Pharmacy Referral Input Screen

Known Allergies: .....

Type of Medication:
Non-ADAP Oral Medications? ...
ADAP-type Medications? ...
ADAP Meds Reason> _____
Nutritional Supplement? ...
Letter of Medical Necessity? ...
Appetite Stimulant? ...
Letter of Medical Necessity? ...
IV Medication? ...
Other Medication Requiring Letter of Medical Necessity? ...

Instructions for Service Delivery:
Client will pick up medications? ___ Pharmacy> _____
Medications delivered? ... Medication Delivery Reason> _____
View/Edit Address Info? ...
Number of Prescriptions Covered by this Referral: __
Additional/Special Instructions: .....
Client's Primary Language> _____

****

- THIS SPACE LEFT BLANK INTENTIONALLY -

III. REFERRAL/RECERTIFICATION - CERTIFICATION

... I certify that this individual meets All Federal, State and Local eligibility requirements for services identified in Section II with funding provided through Title I.

... Our Agency has on file Proof of Client's Medical Eligibility

... Our Agency has on file Proof of Client's Financial Eligibility

... Our agency has on file a Ryan White SDIS Consent to Release and Exchange Information granting release to your agency

... Client has been properly screened for Medicaid and all other public funding as appropriate

... I certify that the services requested are part of the client's care plan

... Our agency has on file proof that the individual is a permanent resident of Miami-Dade County.

****

RFP No. RW1401
ATTACHMENT 35

MIAMI-DADE COUNTY, FLORIDA

OFFICE OF STRATEGIC BUSINESS MANAGEMENT
RYAN WHITE TITLE I PROGRAM
140 WEST FLAGLER STREET
ROOM 1604
MIAMI, FLORIDA 33130-1563
(305) 375-4742
FAX (305) 375-4454

January 23, 2004

Dear Ryan White Title I Service Provider:

RE: Miami-Dade County Notice of Privacy Practices (NOPP)

Effective April 14, 2003, Miami-Dade County adopted a Notice of Privacy Practices (NOPP) in compliance with the privacy, confidentiality, and security of individually identifiable health information and protected health information requirements under the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996.

The County has translated its NOPP making it available in English, Spanish, and Creole. Enclosed are several copies of the trilingual NOPP flyer, poster, and client acknowledgement form. Please make additional copies as needed.

As a reminder, your organization is contractually required to include the NOPP with each intake package provided to clients when they first enroll in the Title I program or the first time they return for reassessment(s). Please be reminded that a copy of the acknowledgement must be kept in the client's file. In addition, this NOPP must also be posted in a visible location at each service site.

The NOPP and client acknowledgement form are currently accessible in the Service Delivery Information System (SDIS) in all three languages.

If you have any questions, please feel free to contact me or Carla Valle-Schwenk, Program Administrator, at (305) 375-4742. Thank you for your cooperation.

Sincerely,

Yocasta Juliao
Project Director

Enclosures

c: Carla Valle-Schwenk,
Program Administrator

Andy Corrigan, President
Automated Case Management Systems, Inc.

Miami-Dade County
Notice of Privacy Practices

It is the policy of Miami-Dade County and all its departments to protect the privacy and confidentiality of all customers' identifiable, personal and confidential information including, but not limited to, protected health information, as required by federal, state and local laws. Our customers are individuals or groups served either directly or indirectly (for example, customers served through business associates) by Miami-Dade County.

We want you to know how we protect this information and how we use it to serve our customers:

- **Your Right to Know**
  You have a right to know what we do with the personal and confidential information we collect about you in the normal course of providing services to our customers. Because we value the integrity of our customer relationships, we want to assure you that we properly safeguard this important information.

- **Personal Information We Collect**
  We collect personal information that you provide to us on applications, other forms and in interviews. In addition, we maintain information of the services you request and/or obtain from us. We may obtain additional information from other parties which may include employers, health care providers, and community agencies in the course of processing your request for services.

- **How We May Use the Information**
  In order to provide you with the highest level of services, we may use or share your information for the purposes of treatment, payment and business operations. There are some services the County conducts through contracts with business associates. We may disclose your information to our business associates so that they can perform the jobs we have asked them to do. To protect the privacy of your information, we contractually require business associates to appropriately safeguard that information. When information is disclosed, the amount of information provided is kept to the minimum necessary.

- **How We May Disclose Information**
  We may disclose your information only with your written authorization, with few exceptions. We will not disclose any information about you or about any other customers or former customers except as authorized by law, as described in this Notice of Privacy Practices or as otherwise communicated to you.

  Law requires disclosure of information in cases of:
  - Child abuse and neglect;
  - Elderly abuse and neglect;
  - Serious threats to health and safety of a person or the public;
  - Public health activities;
  - Health oversight activities; and
  - Law enforcement activities.

- **Your Rights**
  As a customer, you have the right to:
  - have access to your information for review;
  - amend and change your information;
  - restrict access to your information; and
  - know to whom or what agency your information has been disclosed.

- **Protection of Your Information**
  We will protect all information collected about you, and we will restrict access to your personal information by maintaining physical, electronic and procedural safeguards. Employees will be held responsible and accountable for following Notice of Privacy Practices procedures.

Above all, we value you as a customer, your trust and your confidence in our ability to manage and protect your important information. Any concerns regarding this Notice of Privacy Practices or complaints related to the use and handling of your information may be forwarded to the Miami-Dade County's Chief Privacy Officer at (305) 375-4280. You may also file a compliant with the federal Department of Health and Human Services.

Proteger la privacidad de la información identificable, personal y confidencial de todos sus usuarios es norma del Condado de Miami-Dade y de todos sus departamentos. Este amparo alcanza, por ejemplo, a la información relativa a la salud del usuario que protegen las leyes federales, estatales y locales. Todas las personas o grupos a los que el Condado de Miami-Dade les presta servicios, ya sea de manera directa o indirecta (como en el caso de los usuarios que reciben servicio a través de proveedores del Condado), también son sus usuarios.

Queremos hacerle saber cómo respetamos esa información y en qué forma la usamos para prestar servicios a nuestros usuarios:

El derecho de saber

Usted debe saber lo que hacemos con la información personal y confidencial sobre usted que obtenemos en cumplimiento de nuestras tareas diarias. Como queremos preservar la integridad en nuestra relación con los usuarios, le garantizamos que protegemos adecuadamente esa valiosa información.

Información personal que obtenemos

Reunimos la información personal que usted nos proporciona en solicitudes, todo tipo de formularios y entrevistas. Asimismo, llevamos un registro de los servicios que usted nos solicita o le facilitamos. También, en el procesamiento de su pedido de servicio, podemos conseguir información adicional de terceros, como por ejemplo, empleadores, entidades que prestan servicios de salud y agencias comunitarias.

¿Cómo podemos usar la información ?

Con el objeto de prestar servicios de la más alta calidad, tenemos la facultad necesaria para utilizar o compartir su información en relación con tratamientos, pagos y transacciones comerciales. A causa de que el Condado presta algunos servicios mediante proveedores, es nuestra prerrogativa revelarles su información a esos proveedores a fin de que éstos puedan llevar a cabo las tareas que se les hubieran requerido. En miras de la protección de su privacidad, en nuestros contratos con los proveedores les exigimos que pongan a salvo toda información de índole confidencial. Siempre que resulte necesario hacer público algún dato, divulgamos la mínima información posible.

Cómo podemos dar a conocer cierta información

Si bien podemos revelar información pertinente a usted mediante su autorización escrita, existen algunas excepciones. No haremos público ningún dato sobre usted ni sobre ningún otro usuario salvo en la manera en que la ley lo permita o el presente aviso nos autorice o si se le hubiera comunicado al respecto al interesado por algún otro medio.

La ley exige la divulgación de la información en casos de:

- maltrato o atención negligente de niños;
- maltrato o atención negligente de personas mayores;
- amenazas graves a la salud o integridad personal de alguien o a la seguridad del público en general;
- actividades relativas a la salud pública;
- medidas preventivas en el ámbito de la salud y
- actos relativos al cumplimiento de la ley.

Sus derechos

Como usuario, usted tiene los siguientes derechos respecto a la información que le concierne:

- tener libre acceso a ésta para consultas;
- modificarla;
- restringir el acceso a dicha información y
- saber a quién o a qué dependencia se la han dado a conocer datos referentes a usted.

Protección de su información

Mediante recursos físicos, electrónicos y procesales, nos comprometemos a cuidar toda la información que obtengamos sobre usted y a restringir el acceso a ésta por parte de terceros. Todos los empleados asumirán la responsabilidad de acatar los procedimientos detallados en el presente aviso de prácticas en respeto a la privacidad.

Sobre todo, lo apreciamos como nuestro usuario y le agradecemos el hecho de que usted confía en nosotros y en nuestra capacidad para manejar y proteger su información privada. Si usted tiene alguna inquietud con respecto a este aviso de las prácticas referentes a su privacidad o a algún reclamo relacionado con el uso y el manejo de su información confidencial, por favor, haga contacto con el Director de la Oficina de Protección de la Privacidad del Condado de Miami-Dade, por el 305-375-4280. Asimismo, si lo desea, puede presentar reclamos al respecto en el Departamento Federal de Servicios Humanos y de Salud.

869_01-72 5/03

sus derechos

MIAMI-DADE COUNTY

Notice of Privacy Practices

CONTE MIAMI-DADE

Avi Règleman sou Enfòmasyon Pèsonèl

CONDADO DE MIAMI-DADE

Aviso de prácticas en respeto de la privacidad

RFP No. RW1401, ATTACHMENT 35 (continued)

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Miami-Dade County Notice of Privacy Practices

your rights

It is the policy of Miami-Dade County and all its departments to protect the privacy and confidentiality of all customers' identifiable, personal and confidential information including, but not limited to, protected health information, as required by federal, state and local laws. Our customers are individuals or groups served either directly or indirectly (for example, customers served through business associates) by Miami-Dade County.

We want you to know how we protect this information and how we use it to serve our customers:

Your Right to Know

You have a right to know what we do with the personal and confidential information we collect about you in the normal course of providing services to our customers. Because we value the integrity of our customer relationships, we want to assure you that we properly safeguard this important information.

Personal Information We Collect

We collect personal information that you provide to us on applications, other forms and in interviews. In addition, we maintain information of the services you request and/or obtain from us. We may obtain additional information from other parties which may include employers, health care providers, and community agencies in the course of processing your request for services.

How We May Use the Information

In order to provide you with the highest level of services, we may use or share your information for the purposes of treatment, payment and business operations. There are some services the County conducts through contracts with business associates. We may disclose your information to our business associates so that they can perform the jobs we have asked them to do. To protect the privacy of your information, we contractually require business associates to appropriately safeguard that information. When information is disclosed, the amount of information provided is kept to the minimum necessary.

How We May Disclose Information

We may disclose your information only with your written authorization, with few exceptions. We will not disclose any information about you or about any other customers or former customers except as authorized by law, as described in this Notice of Privacy Practices or as otherwise communicated to you.

Law requires disclosure of information in cases of:

- Child abuse and neglect
- Elderly abuse and neglect
- Serious threats to health and safety of a person or the public
- Public health activities
- Health oversight activities
- Law enforcement activities

Your Rights

As a customer, you have the right to:

- have access to your information for review
- amend and change your information
- restrict access to your information
- know to whom or what agency your information has been disclosed.

Protection of Your Information

We will protect all information collected about you, and we will restrict access to your personal information by maintaining physical, electronic and procedural safeguards. Employees will be held responsible and accountable for following Notice of Privacy Practices procedures.

Above all, we value you as a customer, your trust and your confidence in our ability to manage and protect your important information. Any concerns regarding this Notice of Privacy Practices or complaints related to the use and handling of your information may be forwarded to the Miami-Dade County's Chief Privacy Officer at (305) 375-4280. You may also file a compliant with the federal Department of Health and Human Services.

Avi Règleman Konte Miami-Dade sou Enfòmasyon Pèsonèl

dwa w

Se règleman Konte Miami-Dade ak tout depatman li yo pou pwoteje konfidasyalite tout enfòmasyon idantifyab pèsonèl yo, san konte, enfòmasyon sou sante ki pwoteje, jan lwa federal, leta ak lokal yo mande a. Kliyan nou yo se endividi oswa gwoup Konte Miami-Dade sèvi swa dirèkteman oswa endirèkteman (pa egzanp, kliyan kontraktè bay sèvis yo).

Nou vle w konnen kouman nou pwoteje enfòmasyon sa a e kouman nou itilize li pou nou sèvi kliyan nou yo:

Dwa Pou w Konnen

W gen dwa pou w konnen sa nou fè ak enfòmasyon pèsonèl e konfidansyèl nou pran nan men w lè nap bay kliyan nou yo sèvis. Paske entegrite relasyon nou gen ak kliyan nou yo enpòtan pou nou, nou vle asire w ke nou byen pwoteje enfòmasyon enpòtan sa a.

Enfòmasyon Pèsonèl nou Pran

Nou mete ansanm tout enfòmasyon w bannou sou aplikasyon yo, lòt fòm, ak entèvyou. Anplis, nou kenbe enfòmasyon sou sèvis w mande nou e/oswa nou ba w. Nou ka chèche plis enfòmasyon lòt kote, nan men lòt moun - tankou konpayi wap travay, moun/kote ki ba w swen medikal, ak kèk ajans kominotè - lè nap travay sou aplikasyon pou demann w fè pou sèvis yo.

Kouman Nou Ka Itilize Enfòmasyon sila

Pou fasilite nou ba w pi bon sèvis posib, nou ka itilize oswa pataje enfòmasyon w yo pou rezon tankou tretman, peman, ak tranzaksyon komèsyal. Gen kèk sèvis Konte a bay, se kèk asosye biznis (kontraktè) li bay kontra pou pwokire sèvis sa yo. Nou ka divilge enfòmasyon w bay kontraktè nou yo pou fasilite travay nou mande yo fè an. Pou pwoteje enfòmasyon pèsonèl yo, règleman kontra nou bay yo egzije kontraktè yo pwoteje enfòmasyon sila. Se minimòm enfòmasyon ki nesesè ya sèlman nou bay Lè nap divilge enfòmasyon.

Kouman Nou Ka Divilge Enfòmasyon

Se ak otorizasyon w alekri sèlman nou gen dwa divilge enfòmasyon, ak kèk ti grenn eksepsyon. Nou pap divilge okenn enfòmasyon sou w oswa sou okenn lòt kliyan eksepte jan lalwa otorize a, jan yo eksplike nan Avi Règleman sou Enfòmasyon Pèsonèl sila a, oswa pou kèk rezon nou ta fè w konnen.

Lalwa egzije enfòmasyon divilge nan ka sa yo:

- Abize oswa maltrete timoun
- Abize oswa maltrete tigranmoun
- Gwo menas kont sante ak sekirite yon moun oswa piblik la an general
- Patisipasyon nan aktivite sante piblik;
- Aktivite kontwòl sou lasante; ak
- Aktivite lapolis

Dwa w

Kòm kliyan, w gen dwa:

- revize enfòmasyon w yo paske wap gen aksè a dosye w;
- korije ak chanje enfòmasyon w yo;
- limite aksè a enfòmasyon w yo; ak
- konnen a kiyès oswa ki ajans yo divilge enfòmasyon w yo.

Pwoteksyon Enfòmasyon w yo

Nap pwoteje tout enfòmasyon nou gen sou ou w, epi nap limite aksè a enfòmasyon pèsonèl yo nan fason nap mentni sekirite fizik, elektwonik ak pwosedi yo. Anplwaye yo ap gen sou responsabilite yo pou yo swiv pwosedi Avi Règleman sou Enfòmasyon Pèsonèl yo.

Espesyalman, w enpòtan pou nou kòm kliyan, konfyans ke w fè nou pou nou jere ak pwoteje enfòmasyon enpòtan w yo. Nenpòt sousi konsènan Avi Règleman sou Enfòmasyon Pèsonèl sila oswa doleyans ki gen rapò ak fason nou jere e sèvi ak enfòmasyon w yo, w ka kontakte responsab lan "Chief Privacy Officer Konte Miami-Dade" la nan (305) 375-4280. W kapab tou, pote plent bay Depatman Sante ak Sèvis Sosyal Federal yo.

ACKNOWLEDGEMENT OF RECEIPT OF MIAMI-DADE COUNTY NOTICE OF PRIVACY PRACTICES (NOPP) RYAN WHITE TITLE I PROGRAM

I, _____ , hereby acknowledge that I received a copy of the Miami-Dade County Notice of Privacy Practices (NOPP) as required by the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 on the _____ day of _____ , 2003.

_____
Name (Please Print)

_____
Signature

_____
CIS #:

EL RECONOCIMIENTO DEL RECIBO DEL AVISO DEL CONDADO DE MIAMI-DADE DE LAS PRÁCTICAS EN RESPETO DE LA PRIVACIDAD (NOPP) DEL PROGRAMA "RYAN WHITE TITLE I"

Yo, _____ , reconozco por este medio que he recibido una copia del aviso del condado de Miami-Dade de las Prácticas en Respeto de la Privacidad (NOPP) según los requisitos del Acto Federal de la Portabilidad y de la Responsabilidad del Seguro Médico (HIPAA) de 1996 en el _____ día de _____ de 200__.

_____
Su Nombre (Imprima por favor)

_____
Su Firma

_____
Número del Sistema de Información del Cliente (CIS#)

MWEN REKONET KE MWEN RESEVWA DE AVI RÈGLEMAN DE KONTE MIAMI-DADE SOU ENFÒMASYON PÈSONÈL (NOPP) - "RYAN WHITE TITLE I PROGRAM"

Mwen, _____, dako ke mwen resevwa yon kopi de sa yo rele Avi Règleman Konte Miami-Dade sou Enfòmasyon Pèsonèl (NOPP) Kom federal "Health Insurance Portability and Accountability Act (HIPAA) 1996" lan exige'li, lan jou _____ 200__ .

_____
Non-w (let d'amprent)

_____
Siyati

_____
Nimero sistem d'enfòmasyon klian: NSE # (CIS #)

RFP No. RW1401
ATTACHMENT 36

PROPOSAL SUBMISSION CHECKLIST
HEALTH AND SUPPORT SERVICES FOR PERSONS
WITH HIV SPECTRUM DISEASE
(RFP No. RW1401)

Proposing Organization: _____

Reviewed By: _____

	SECTIONS OF THE PROPOSAL		ATTACHMENT/ APPENDIX
A		Proposal Title Page	Attachment 2
B		Table of Contents	-
C		Minimum Qualification Requirements	-
D		Service Abstract (complete this section once for each proposed service)	-
E		Service Experience (complete this section once)	-
	E1	Organizational History and Corporate/Tax Status	Appendix 1
	E2	Staff's Experience Providing Services to HIV/AIDS Clients	-
	E3, 4	Organization's Medicaid Experience and Medicaid Eligible Client Load	-
	E5	Organization's Capability to Respond to Special Client Groups	-
	E6	Organization's Client Orientation Process	-
	E7	Organization's Client Screening Process	-
	E8	Organization's Referral Process & Referral Agreements	Appendix 2
	E9	Organization's Policies Regarding Initiation and Update of Client Files	-
	E10	Organization's Data Collection and Reporting Activities	Attachments 29 - 31

**Complete this section once for each proposed service.*

	SECTIONS OF THE PROPOSAL		ATTACHMENT/ APPENDIX
	E11	Certified Financial Audit Report	Appendix 3
	E12	Organization's Confidentiality Policies & Procedures	-
	E13	Organization's Quality Assurance Policies & Procedures, Including Training Curriculum	Include as an Appendix if Applicable (Provide Appendix #)
	E14	Organization's Customer Service Policies & Procedures	-
	E15	Organization's Grievance Policies & Procedures	Appendix 4
	E16	Involvement of Persons Living with HIV/AIDS in the Organization's Decision Making Process	-
	E17	Compliance with Ryan White Title I System-wide Standards of Care	Attachment 25
	E18	Organization's Non-Discrimination Policy Statement	-
	E19	List of Board of Directors, Officers of the organization, and Advisory council Members and ethnic breakdown of Board and Staff (Professional or Volunteer)	Appendix 5
	E20	Description of Prior or Pending Litigation	-
F		Proposed Service *	
	F1	Organization's Past Experience in Providing Proposed Service	-
	F2	Organization's Current Experience in Providing Proposed Service & Funding Source Summary Form	Attachment 33
	F3	Level of Need/Demand for Proposed Service	-
	F4	Description of Service Expansion and/or Modification and Information Regarding For-Profit Organizations	Attachment 1
	F5	Description of Proposed Service	-

**Complete this section once for each proposed service.*

	SECTIONS OF THE PROPOSAL		ATTACHMENT/ APPENDIX
	F6	Organization's Policies Regarding Quality of Care in the Provision of the Proposed Service and Services to HIV/AIDS Clients	-
	F7	Organization's Intake Process	-
	F8	Schedule of Services, Service Locations, Number of Clients to be Served, Number of Service Units to be Provided	-
	F9, 10	Organization's Case Management Activities and compliance with Title I Coordinated Case Management Standards of Service (if applicable)	Attachment 26
	F11	Organization's Outpatient Medical Care (Primary Care) and compliance with the Minimum Primary Care Standards for Chart Review (if applicable)	Attachment 27
	F12	Staff Availability & Name of Contract Coordinator	-
	F13	Organization and Staff Licenses	Appendix 6
	F14	Resumes & Job Descriptions	Appendix 7
	F15	Work Plan Form	Attachment 32
G		Line Item Budget & Price Forms *	-
	G1	Detailed Line Item Budget with Narrative Justification and, if applicable, Unit Cost Calculations	Attach. 15 - 16
	G2	Price Forms	Attach. 20 – 21a and 22 – 24b
H		Required Affidavits/Acknowledgments	-
	H1	Acknowledgment of Addenda	Attachment 3
	H2	Miami-Dade County Lobbyists Registration for Oral Presentation	Attachment 4

**Complete this section once for each proposed service.*

	SECTIONS OF THE PROPOSAL		ATTACHMENT/ APPENDIX
	H3	Affidavit that Miami-Dade County Taxes, Fees and Parking Tickets Have Been Paid	Attachment 11
	H4	Disability Nondiscrimination Affidavit	Attachment 14
	H5	Local Business Preference	Attachment 6
	H6a	Subcontractor/Supplier Form	Attachment 7
	H6b	Fair Subcontracting Policies	Attachment 8
	H7a	Affirmative Action Plan/Procurement Policy Affidavit	Attachment 9
	H7b	Affirmative Action Plan Exemption Affidavit	Attachment 10
	H8	Code of Business Ethics	Attachment 12
	H9	Disclosure of Criminal Record (Submit Prior to Entering into a Contract with the County, and only if applicable)	-
	H10	Domestic Violence Leave Affidavit (submit only if applicable)	Attachment 13